

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-022213
STATE FILE NUMBER

FILED JUN 19 1959

Registration District No. 217 Primary Registration District No. 5786 Registrar's No. 46

S. 300
1-57

1. PLACE OF DEATH a. COUNTY Mississippi		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Mississippi	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Wyatt		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	c. CITY OR TOWN Wyatt
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION		Length of stay in 1b 5 yrs	d. STREET ADDRESS (If outside, give location) R.F.D.
3. NAME OF DECEASED (Type or print) First Middle Last Vernon Lovingood			4. DATE OF DEATH Month Day Year 5---28--59
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 28 1953
9. AGE (In years last birthday) 5		IF UNDER 1 YEAR Months Days 10	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Child		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) Birds Point Mo.
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13a. FATHER'S NAME not known	
13b. MOTHER'S MAIDEN NAME Jessie Mae Lovingood		14. NAME OF HUSBAND OR WIFE child	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT Jessie Mae Parker Address Wyatt MO. R.F.D.
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Presumed to be natural causes. DUE TO (b) (Coroner of Miss. Co. Notified) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)			INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT SUICIDE HOMICIDE <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour a.m. Month, Day, Year p.m.		20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION COUNTY STATE	
21. I attended the deceased from _____ to _____ and last saw her alive on _____ Death occurred at 5:00 A m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) Dorothy B. Hathorn, local Registrar Charleston Mo.		22b. ADDRESS	22c. DATE SIGNED 6-5-59
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE June 4 1959	23c. NAME OF CEMETERY OR CREMATORY Oak Grove	23d. LOCATION (City, town, or county) (State) Charleston Missouri
24. FUNERAL DIRECTOR ADDRESS Peoples Funeral Chapel		25. DATE RECD. BY LOCAL REG. 6-12-59	26. REGISTRAR'S SIGNATURE Dorothy B. Hathorn

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
MEDICAL CERTIFICATION

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

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STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by, Student Embalmer No. working under my personal supervision.

Student
Signature of Student Embalmer

Signed *E. J. Malden*

Licensed Embalmer No. *4935*
P. O. Address *Chalcuton*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).
If embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.