

IRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

531

-60-014886

FILED VS MAY 16 1960

STATE FILE NUMBER

Registration District No. 128 Primary Registration District No. 2000 Registrar's No. ~~2000~~

INDEXED

1. PLACE OF DEATH a. COUNTY Greene		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Greene	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Springfield		Length of stay in 1b 1 day	c. CITY OR TOWN Springfield Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Handley Hospital		d. STREET ADDRESS (If outside, give location) Duncun Rest Home	Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Valentine Middle R. Last Lovett			4. DATE OF DEATH Month May Day 5 Year 1960			
5. SEX M	6. COLOR OR RACE W	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 8-5-1869	9. AGE (last birthday) 90	IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/>	IF UNDER 24 HR Hours <input type="checkbox"/> Min. <input type="checkbox"/>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farm		11. BIRTHPLACE (City and state or country) Billings, Mo.		12. CITIZEN OF WHAT COUNTRY USA
13a. FATHER'S NAME Mickel Lovett			13b. MOTHER'S MAIDEN NAME Melissa Owen		14. NAME OF HUSBAND OR WIFE None	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. none		17. INFORMANT Olen Lovett		Address Republic, Mo.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio-vascular Disease		INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (b), stating the underlying cause last.	DUE TO (b) Fractured Hip	
	DUE TO (c)	

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
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19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input checked="" type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) Fell out of Bed at Nursing Home	
20c. TIME OF INJURY Hour <input type="checkbox"/> a.m. <input checked="" type="checkbox"/> p.m. May 5 60			

20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office, etc.) Nursing Home Route 4 Springfield, Greene, Mo.	20f. CITY, TOWN, OR LOCATION Springfield, Greene, Mo.	COUNTY Greene	STATE Mo.
21. I attended the deceased from May 5, 1960 to May 5, 1960 and last saw him alive on May 5, 1960 Death occurred at 7 p.m. on the date stated above, and to the best of my knowledge, from the causes stated.				

22a. SIGNATURE (Degree or title) Lynn R. Brown M.D.		22b. ADDRESS 311 1/2 College		22c. DATE SIGNED 5/11/60
23a. BURIAL, CREMATION, OR REMOVAL (Specify) Burial	23b. DATE 5-8-1960	23c. NAME OF CEMETERY OR CREMATORY Garoutte Cemetery	23d. LOCATION (City, town, or county) (State) Republic, Mo.	
24. FUNERAL DIRECTOR W.B. Cantrell Republic, Mo.		25. DATE RECD. BY LOCAL REG. 5-12-60	26. REGISTRAR'S SIGNATURE Effie S. Melton	

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

MAY 27 1960

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 William A. Coulter

Licensed Embalmer No. 4820

P. O. Address Republic

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.