

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

60-020314
State File No.

FILED VS JUN 6 1960

BIRTH NO. _____ REG. DIST. NO. 212 PRIMARY REG. DIST. NO. 5968 Registrar's No. _____

1. PLACE OF DEATH a. COUNTY Pemiscot		2. USUAL RESIDENCE (Where deceased lived. If Institution: residence before admission) a. STATE Missouri b. COUNTY Pemiscot	
b. CITY (If outside corporate limits, write RURAL and give OR TOWN Hermendale)		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Hermendale 0780-	
d. FULL NAME OF HOSPITAL OR INSTITUTION None 90		d. STREET ADDRESS (If rural, give location) Rt. 1 Steele, Mo.	

3. NAME OF DECEASED (Type or Print) a. (First) Reginer	b. (Middle)	c. (Last) Lovelady	4. DATE OF DEATH (Month) (Day) (Year) 4 2 60
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5. SEX Female	6. COLOR OR RACE Colored	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH 2/7/1894	9. AGE (In years, months, days) 66 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Common laborer	10b. KIND OF BUSINESS OR INDUSTRY Any	11. BIRTHPLACE (State or foreign country) Mississippi	12. CITIZEN OF WHAT COUNTRY? /
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13a. FATHER'S NAME Tom Alexander	13b. MOTHER'S MAIDEN NAME Unknown	14. NAME OF HUSBAND OR WIFE Charley Lovelady
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give branch and date of service) None	16. SOCIAL SECURITY NO. None	17. INFORMANT'S SIGNATURE OR NAME Tom Alexander Dell, Ark.	ADDRESS
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Chronic Myocarditis		INTERVAL BETWEEN ONSET AND DEATH 4 75 yrs
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____		
	II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. 4222		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
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21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
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22. I hereby certify that I attended the deceased from **4-1-58**, 19___, to **4-2-**, 19 **60**, that I last saw the deceased alive on **4-1-**, 19___, and that death occurred at ___ m., from the causes and on the date stated above.

23a. SIGNATURE H. M. Wanic	(Degree or title)	23b. ADDRESS Steele 4nd	23c. DATE SIGNED 4-21-60
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24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE 4/10/60	24c. NAME OF CEMETERY OR CREMATORY Mt. Zion Cem.	24d. LOCATION (City, town, or county) (State) Blytheville, Ark.
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DATE REC'D BY LOCAL REG. 6-6-60	REGISTRAR'S SIGNATURE H. M. Wanic	25. FUNERAL DIRECTOR'S SIGNATURE McGill V. Horne	ADDRESS Blytheville, Ark.
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

1961 & 1 FORM

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 _____

Paul Horne
working under my personal supervision.

Student Embalmer No.

Signed.....
Student Embalmer

Signed Paul Horne
Licensed Embalmer No. 1073

P. O. Address Bethesda

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 this body is not embalmed, fact should be so stated above.