

FEDERAL DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-027467

FILED JUL 20 1960

STATE FILE NUMBER

Registration District No. 170 Primary Registration District No. — Registrar's No. 102

INDEXED

1. PLACE OF DEATH a. COUNTY <u>Laclede.</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> COUNTY <u>Pulaski</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Oakland</u>	Length of stay in lb <u>3 Months</u>	c. CITY OR TOWN <u>Crocker, Missouri</u>	Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>St Green Nursing H.</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>None.</u>
Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			

3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>Riley</u> Last <u>Lovell.</u>			4. DATE OF DEATH Month <u>June</u> Day <u>27</u> Year <u>1960</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White.</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>5/7/1886</u>	9. AGE (last birthday) <u>74</u>	IF UNDER 1 YEAR Months <u> </u> Days <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u> </u>	11. BIRTHPLACE (City and state or country) <u>Pulaski Co Missouri</u>	12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13a. FATHER'S NAME <u>James Lovell.</u>		13b. MOTHER'S MAIDEN NAME <u>Elizabeth Ledbetter.</u>		14. NAME OF HUSBAND OR WIFE <u>Rosie Lovell.</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>489 16 0103</u>	17. INFORMANT Address <u>Mr. Joseph Powers Richland, Mo</u>		

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral vascular accident (hemorrhage)</u>		INTERVAL BETWEEN ONSET AND DEATH <u>5 days.</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>Arteriosclerosis, Generalized</u>	
	DUE TO (c) <u> </u>	

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.)	
20c. TIME OF INJURY Hour <u> </u> a.m. <u> </u> p.m.	Month, Day, Year <u> </u>		
20d. INJURY OCCURRED WHILE AT WORK <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 6-22-57 to 6-27-60 and last saw ^{her}him alive on 6-26-60
Death occurred at 9:30A on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <u>B B Hurst, M.D.</u>	22b. ADDRESS <u>Lebanon, Mo.</u>	22c. DATE SIGNED <u>7-7-60</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>6/29/1960</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Crocker Memorial Conet. Crocker, Mo</u>	23d. LOCATION (City, town, or county) (State) <u>Crocker, Mo</u>
24. FUNERAL DIRECTOR <u>W. J. Kelly, Richland Mo</u> <u>Wesley Funeral Home, Crocker, Mo</u>	25. DATE RECD. BY LOCAL REG. <u>7-9-1960</u>	26. REGISTRAR'S SIGNATURE <u>Hella L. May</u>	

(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

STATEMENT BY LICENSED EMBALMER

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

Student _____
Signature of Student Embalmer

Signed J. R. Palmor

Licensed Embalmer No. 4810

P. O. Address Lebanon

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.