

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-036334

FILED VS OCT 6 1960 318

1003

9341

STATE FILE NUMBER

Registration District No. Primary Registration District No. Registrar's No.

DED

1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Lafayette				
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		Length of stay in 1b 12 Hrs		c. CITY OR TOWN Higginsville,		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Louis-Little Rock Hospital Inc.			Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS Rt 1		(If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Thomas William Love				4. DATE OF DEATH Month Day Year Sept. 22, 1960				
5. SEX Male	6. COLOR OR RACE White	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH 4-28-1884	9. AGE (last birthday) 76 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Pensr. Road Foreman of Engines Railroad			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) Lexington Mo.		12. CITIZEN OF WHAT COUNTRY USA.	
13a. FATHER'S NAME Dudley Love			13b. MOTHER'S MAIDEN NAME Jennie Owens			14. NAME OF HUSBAND OR WIFE Myrtle		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes World war #1			16. SOCIAL SECURITY NO.		17. INFORMANT Address Myrtle Love Higginsville 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) Multiple Myeloma DUE TO (b) DUE TO (c) 203x							INTERVAL BETWEEN ONSET AND DEATH	
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		
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20a. ACCIDENT <input 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 Month, Day, Year								
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 Sept. 21, 1960 to Sept. 22, 1960 and last saw him alive on Death occurred at 6:30 AM on the date stated above, and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE (Degree or title) D. B. Boyd M.D.			22b. ADDRESS 1755 S. Grand Blvd			22c. DATE SIGNED SEP 22 1960		
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE 9-25-60	23c. NAME OF CEMETERY OR CREMATORY Sedalia Cemetery		23d. LOCATION (City, town, or county) Sedalia Mo.		23e. STATE	
24. FUNERAL DIRECTOR ADDRESS Haefner Funeral Home Higginsville, Mo.				25. DATE RECD. BY LOCAL REG. SEP 22 1960		26. REGISTRAR'S SIGNATURE Loan Smith, M.D.		

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

JUL 26 1960

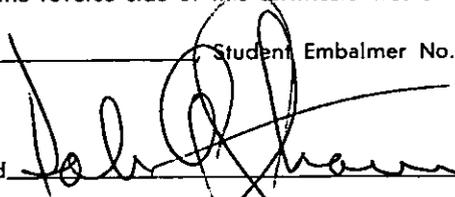
OCT 18 1960

OCT 9 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 \_\_\_\_\_ or by \_\_\_\_\_ Student Embalmer No. \_\_\_\_\_ working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed  \_\_\_\_\_

Licensed Embalmer No. 453

P. O. Address St Joe

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.