

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-62-002713

STATE FILE NUMBER

AMENDED

Registration District No. 209 Primary Registration District No. _____ Registrar's No. 1

FILED FEB 14 1962

| | | | | | | | | | | | | | | | |
|---|--|---|--|---|---|--|---|--|--------|---|--|----------------|--|--|--|
| 1. PLACE OF DEATH a. COUNTY <u>Marion</u> | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Marion</u> | | | | | | | | | | | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Fabius township</u> | | Length of stay in 1b <u>2 yrs</u> | | c. CITY OR TOWN <u>Palmyra</u> | | Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | | | | | | | | | |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>R#1</u> | | | Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/> | | d. STREET ADDRESS (If outside, give location) <u>R#1</u> | | Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | | | | | | | | |
| 3. NAME OF DECEASED (Type or print) First <u>JULIE</u> Middle <u>ANN</u> Last <u>LOVELACE</u> | | | | 4. DATE OF DEATH Month <u>Jan.</u> Day <u>12</u> Year <u>1962</u> | | | | | | | | | | | |
| 5. SEX <u>Female</u> | | 6. COLOR OR RACE <u>White</u> | | 7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> | | 8. DATE OF BIRTH <u>June 22 1949</u> | | 9. AGE (last birthday) <u>2</u> | | IF UNDER 1 YEAR Months <u>0</u> Days _____ Hours _____ Min. _____ | | IF UNDER 24 HR | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | | | 10b. KIND OF BUSINESS OR INDUSTRY | | | | 11. BIRTHPLACE (City and state or country) <u>Hannibal Mo.</u> | | 12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u> | | | | | |
| 13a. FATHER'S NAME <u>Lloyd E. Lovelace</u> | | | | 13b. MOTHER'S MAIDEN NAME <u>Ellen M. Beckgerd</u> | | | | 14. NAME OF HUSBAND OR WIFE | | | | | | | |
| 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. | | | | 17. INFORMANT <u>Lloyd Lovelace R#1 Palmyra, Mo.</u> | | | | Address | | | |
| 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>Bronchial pneumonia</u> | | | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u> | | | | | |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ | | | | | | | | | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Cerebral ataxia since birth</u> | | | | | | | | | | PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown | | | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" 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 _____ a.m. _____ p.m. | | 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 <u>Jan 11, 1962</u> to <u>Jan 12, 1962</u> and last saw her alive on <u>Jan 19, 1962</u> Death occurred at _____ on the date stated above, and to the best of my knowledge, from the causes stated. | | | | | | | | | | | | | | | |
| 22a. SIGNATURE <u>[Signature]</u> (Degree or title) <u>M.D.</u> | | | | | | 22b. ADDRESS <u>Palmyra Mo.</u> | | | | 22c. DATE SIGNED <u>1/15/62</u> | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 23b. DATE <u>Jan. 13 1962</u> | | 23c. NAME OF CEMETERY OR CREMATORY <u>Greenwood Cem.</u> | | | | 23d. LOCATION (City, town, or county) <u>Palmyra Mo.</u> | | | | | | | |
| 24. FUNERAL DIRECTOR <u>E. T. Sprague</u> ADDRESS <u>Palmyra, Mo.</u> | | | | 25. DATE RECD. BY LOCAL REG. <u>1-15-62</u> | | | | 26. REGISTRAR'S SIGNATURE <u>Dr. E. M. Luede</u> <u>By Viola Lee, Deputy</u> | | | | | | | |

AMENDED
 DATE AMENDED
 INSTEAD OF
 DOCUMENT
 MEDICAL CERTIFICATION
 SHOULD READ
 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 me,

or by _____, Student Embalmer No. _____

working under my personal supervision.

Student _____

Signature of Student Embalmer

Signed E. J. Sprague

Licensed Embalmer No. 3245

P. O. Address Palmyra, Mo.

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.