

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

PLACE OF DEATH

County Pettis
Township Dresden
or
Village _____
or
City _____ (NO. _____ St. _____ Ward _____)

Registration District No. 672 File No. 17180
Primary Registration District No. 3895 Registered No. _____

FULL NAME Williams P. Lovelace

(If death occurred in a hospital or institution, give its NAME instead of street and number)

PERSONAL AND STATISTICAL PARTICULARS

SEX Male COLOR OR RACE White SINGLE MARRIED WIDOWED OR DIVORCED Married
(Write the word)

DATE OF BIRTH _____ (Month) _____ (Day) _____ (Year)

AGE 49 yrs. _____ mos. _____ ds. If LESS than 1 day, _____ hrs. or _____ min.?

OCCUPATION (a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer) General farmer

BIRTHPLACE (City or town, State or foreign country) Pettis County, Mo.

PARENTS NAME OF FATHER James M. Lovelace

BIRTHPLACE OF FATHER (City or town, State or foreign country) North Carolina

MAIDEN NAME OF MOTHER Nancy Erwin

BIRTHPLACE OF MOTHER (City or town, State or foreign country) Pettis Co. Mo.

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) W. Lovelace

(ADDRESS) 1901 North Main Sdalia, Mo.

Filed 6/8 1910 John A Powers REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH June 8, 1910
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from 5/12, 1910, to 6/8, 1910, that I last saw him alive on 6/8, 1910, and that death occurred, on the date stated above, at 2 a.m. The CAUSE OF DEATH* was as follows:

23h
100% typhoid Pneumonia

(Duration) yrs. _____ mos. 27 ds.
Contributory Tuberculosis
(SECONDARY) (Duration) yrs. _____ mos. _____ ds.

(Signed) John A Powers M. D. 6/8, 1910 (Address) Dresden

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.

Where was disease contracted if not at place of death? _____ Former or usual residence _____

PLACE OF BURIAL OR REMOVAL Wegansette DATE OF BURIAL 6/9, 1910
UNDERTAKER None ADDRESS _____

