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: Nodaway

Township or Village or City: Ravenwood (NO. ____ St.: ____ Ward)

Registration District No. 629 — File No. 19448

Primary Registration District No. 4379 — Registered No. 11

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

FULL NAME: Viola May Loomis

PERSONAL AND STATISTICAL PARTICULARS

SEX: Female — COLOR OR RACE: White — SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)

DATE OF BIRTH: May 31" (Month) (Day), 1917 (Year)

AGE: ✓ yrs. ✓ mos. ✓ ds. — If LESS than 1 day, 8 hrs. or 2 min.?

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

BIRTHPLACE (City or town, State or foreign country): Ravenwood, Mo.

PARENTS
NAME OF FATHER: Delbert Rhoads
BIRTHPLACE OF FATHER (City or town, State or foreign country): Ia.
MAIDEN NAME OF MOTHER: Alma Loomis
BIRTHPLACE OF MOTHER (City or town, State or foreign country): Mo.

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Delbert Rhodes

(ADDRESS) Ravenwood, Mo.

Filed 6-1- 1917. Dr. Ole Kessler, REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH: May 31" (Month) (Day), 1917 (Year)

I HEREBY CERTIFY, that I attended deceased from May 31", 1917, to May 31", 1917, that I last saw her alive on May 31", 1917, and that death occurred, on the date stated above, at 5 P. m.

The CAUSE OF DEATH* was as follows:

Premature birth.

159

(Duration) ____ yrs. ____ mos. ____ ds.

Contributory (SECONDARY) ____

(Duration) ____ yrs. ____ mos. ____ ds.

(Signed) Ole Kessler, M. D.

6-1- 1917 (Address) Ravenwood, Mo.

*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: Ravenwood, Mo. — DATE OF BURIAL: 6-1- 1917

UNDERTAKER: S. P. Ross — ADDRESS: Ravenwood, Mo.

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

PLACE OF DEATH

County.....

Township ..... Registration District No. ..... File No. .....

or

Village ..... Primary Registration District No. ..... Registered No. .....

or

City ..... (NO. ....., ... St.: ..... Ward)

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

FULL NAME .....

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.

PERSONAL AND STATISTICAL PARTICULARS

SEX	COLOR OR RACE	SINGLE MARRIED WIDOWED OR DIVORCED (*Write the word*)

DATE OF BIRTH

..... , 1.....
(Month) (Day) (Year)

AGE

.....yrs. .....mos. .....ds.

If LESS than 1 day, ...hrs. or .....min.?

OCCUPATION
(a) Trade, profession, or particular kind of work .....

(b) General nature of industry, business, or establishment in which employed (or employer) .....

BIRTHPLACE
(City or town, State or foreign country)

PARENTS

NAME OF FATHER

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

MAIDEN NAME OF MOTHER

BIRTHPLACE OF MOTHER
(City or town, State or foreign country)

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) .....

(ADDRESS) .....

Filed ....., 191....., ...
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH

....., 191....
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from ....., 191....., to ....., 191....., that I last saw h..... alive on ....., 191....., and that death occurred, on the date stated above, at .....m.

The CAUSE OF DEATH* was as follows:

.....

.....

.....

.....(Duration).....yrs. .....mos. .....ds.

Contributory .....
(SECONDARY)

.....(Duration).....yrs. .....mos. .....ds.

(Signed) ..... M. D.

....., 191.... (Address) .....

*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	DATE OF BURIAL
	....., 191....
UNDERTAKER	**ADDRESS**