

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

Do not use this space.

15374

**1. PLACE OF DEATH**

County.....  
Township.....  
City.....

Registration District No.....  
Primary Registration District No.....  
(No. 1339 January St.)

791

File No.....  
Registered No. 3695  
St. .... Ward)

**2. FULL NAME**

(a) Residence. No. .... St. 4 Ward. ....  
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds. (If nonresident give city or town and State)

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX Male  
4. COLOR OR RACE Col  
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Single

5A. If MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 6-17-1925

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, hrs. or min.
	1	10		

**8. OCCUPATION OF DECEASED**

(a) Trade, profession, or particular kind of work None  
(b) General nature of industry, business, or establishment in which employed (or employer)  
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) St Louis MO-  
(STATE OR COUNTRY)

10. NAME OF FATHER Thos Lovings

11. BIRTHPLACE OF FATHER (CITY OR TOWN) St Louis MO-  
(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER Louella Burkett  
(STATE OR COUNTRY)

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Ark  
(STATE OR COUNTRY)

14. INFORMANT Thos Lovings.  
(Address) 1339 January Ave

15. FILED APR 18 1937 Thos C. Starkeoff  
REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) April 17 1937

17. I HEREBY CERTIFY, That I attended deceased from ..... 19....., to ..... 19....., and that I last saw him alive on ..... 10.30.00, on the date stated above, at.....

THE CAUSE OF DEATH\* WAS AS FOLLOWS:  
Acute Bronchitis  
10.30.00  
8h  
Consolidation  
(duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY) (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED  
IF NOT AT PLACE OF DEATH

DID AN OPERATION PRECEDE DEATH? DATE OF

WAS THERE AN AUTOPSY?

WHAT TEST CONFIRMED DIAGNOSIS?  
(Signed) [Signature] M. D.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Greenwood  
DATE OF BURIAL 4/18 1937  
ADDRESS [Address]  
\*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, OR HOMICIDAL.

20. UNDERTAKER Thos J. Yates 4107 Quincy

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.

ENVIRONMENT RECORD

