1321

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

Do not use this space.

File No. 27572
Registered No. 463

1. PLACE OF DEATH
County: Jasper
Township:
City: Joplin Mo (No. ..... St. ..... Ward)
Registration District No. 411
Primary Registration District No. 2002

2. FULL NAME Albert L. Lovejoy
(a) Residence. No. 1 Joplin St. Ward.
(Usual place of abode) (If nonresident give city or town and State)
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.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: Colored
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word): Married

5A. IF MARRIED, WIDOWED, OR DIVORCED
HUSBAND OF (OR) WIFE OF Mrs Renora Lovejoy

6. DATE OF BIRTH (MONTH, DAY AND YEAR) May 18 1890

7. AGE: Years 37 | Months 4 | Days 11 | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Farmer
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): Kansas

PARENTS
10. NAME OF FATHER: J. J. Lovejoy
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY): Alabama
12. MAIDEN NAME OF MOTHER: Elizabeth Wright
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY): Alabama

14. INFORMANT: Mrs Renora Lovejoy
(Address): Baxter Springs Ks

15. FILED 9/29, 1927 A. Benson Clark, Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Sept. 29 1927

17. I HEREBY CERTIFY, That I attended deceased from Sept. 14, 1927, to Sept. 29, 1927 that I last saw ~~him~~ alive on Sept. 29, 1927, and that death occurred, on the date stated above, at ..... m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Abcess Lung
V3H
(duration) ..... yrs. 1 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) H. C. Lowry, M. D
9/29, 1927 (Address) Joplin Mo

*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.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL: Baxter Springs, Ks — DATE OF BURIAL: Oct 2 1927

20. UNDERTAKER: Harvey Lund Co — ADDRESS: Baxter Springs Ks

N. B.—Every item of information should be 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.

Air Farmers

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

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH

County: Jasper — Registration District No.: #11 — File No.:

Township: — Primary Registration District No.: 2002 — Registered No.: #63

City: Joplin (No. , St. Ward)

2. FULL NAME Albert L. Lovejoy

(a) Residence. No. St., Ward
(Usual place of abode) (If nonresident give city or town and State)

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.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write* the word)
M	B	M

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

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

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN)
(STATE OR COUNTRY)

PARENTS
10. NAME OF FATHER
11. BIRTHPLACE OF FATHER (CITY OR TOWN)
(STATE OR COUNTRY)
12. MAIDEN NAME OF MOTHER
13. BIRTHPLACE OF MOTHER (CITY OR TOWN)
(STATE OR COUNTRY)

14. INFORMANT
(Address)

15. FILED 11/14 1927 M Duncan Clark
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Sept 29 1927

17. I HEREBY CERTIFY, That I attended deceased from , 19, to , 19, that I last saw h. alive on , 19, and that death occurred, on the date stated above, at m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Abscess Lung
Tuberculosis
(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) , M. D.
, 19 (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. (See reverse side for additional space.)

19. PLACE OF BURIAL, CREMATION, OR REMOVAL	DATE OF BURIAL 19
20. UNDERTAKER	ADDRESS

SUPPLEMENTARY

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REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

...E should be stated EXACTLY. PHYSICIANS should state ...mation should be careful... classified. Exact statement of OCCUPATION is very important.

S-27572