

SEP 27 1926

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

Do not use this space.

28073 *Full*

1. PLACE OF DEATH

County Oregon Registration District No. 632
Township Hayes Primary Registration District No. 4382
City Prineville (No. 5174) St. _____ Ward _____

2. FULL NAME Miss Leandrey Lovelace

(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 fe 4. COLOR OR RACE Wh 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Single

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

7. DATE OF BIRTH (MONTH, DAY AND YEAR) Aug-13-1928

7. AGE YEARS MONTHS DAYS 6 If LESS than 1 day, _____ hrs. or _____ min.

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

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

PARENTS

10. NAME OF FATHER Robert Lovelace

11. BIRTHPLACE OF FATHER (CITY OR TOWN) Oregon Co.
(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER Madge Childers

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

14. INFORMANT A. H. Carr
(Address) Hayes

15. FILED Aug 22 28 R. R. Rea
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 8-19-28

17. I HEREBY CERTIFY, That I attended deceased from 8-18, 1928, to _____, 19____, that I last saw him _____ alive on 8/18/28, 19____, and that death occurred, on the date stated above, at 12:57 m.

18. THE CAUSE OF DEATH* WAS AS FOLLOWS:
Acute Indigestion
IBC
(duration) 2 yrs. 0 mos. 1 ds.
CONTRIBUTORY (SECONDARY) 1
(duration) _____ yrs. _____ mos. _____ ds.

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

19. DID AN OPERATION PRECEDE DEATH? ✓ DATE OF _____
WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS? ✓
(Signed) H. B. Hull, M. D.
, 19____ (Address) Mammoth Spring Ark

*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 Walker Cemetery DATE OF BURIAL 8/21-1928

20. UNDERTAKER _____ ADDRESS _____

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

ALL INFORMATION CALLED
FOR MUST BE WRITTEN ON
THIS SUPPLEMENTARY.

1. PLACE OF DEATH.

County Oregon
Township Hayes
City (No.) St. Ward)

Registration District No. 637
Primary Registration District No. 5-834

File No.
Registered No.
St. Ward)

2. FULL NAME

Alice Leandrey Lovelace
(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 F 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED S (write the word)

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)

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)

FILED Aug 28 1928 6:15 a

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 8-19-28 1928

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

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Acute Indigestion
about
one hour.
Dr. Ross (duration) mo. ds.

CONTRIBUTORY (SECONDARY) was doing about
what when the (duration) yrs. ds.

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

DID AN OPERATION PRECEDE DEATH? DATE OF

WAS THERE AN AUTOPSY? DATE OF

WHAT TEST CONFIRMED DIAGNOSIS? 1/20

(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.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL DATE OF BURIAL

20. UNDERTAKER Al. Con ADDRESS Mojo

19

N. B. - Information should be carefully supplied. AGE should be stated in plain terms, so that it can be properly classified. Exact statement of OCCUPATION is very important.

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

SUPPLEMENTARY

S-28073