JAN 22 1929

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

Do not use this space.

33156-B

1. PLACE OF DEATH
County Dallas
Township S. Benton
City Buffalo (No. ..... St. ..... Ward)
Registration District No. 241
Primary Registration District No. [illegible]
File No. 311
Registered No. .....

2. FULL NAME Lovanne Hunt
(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 (write the word) M

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 2/28/1870

7. AGE

YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
58	7	5	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(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) Ill.

PARENTS
10. NAME OF FATHER West Epley
11. BIRTHPLACE OF FATHER (CITY OR TOWN) .....
(STATE OR COUNTRY) Unknown
12. MAIDEN NAME OF MOTHER Blevins
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) .....
(STATE OR COUNTRY) Ill

14. INFORMANT A. F. Hunt
(Address) Buffalo, Mo.

15. FILED 12/20, 1928 Harvey Morrow
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 10/3 1928

17. I HEREBY CERTIFY, That I attended deceased from Dec, 1925, to Oct 3, 1928, that I last saw her alive on Oct 3, 1928, and that death occurred, on the date stated above, at 9 A. m.

23A THE CAUSE OF DEATH* WAS AS FOLLOWS:
23B Pulmonary Hemorrhage
Pulmonary Tuberculosis
..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (SECONDARY) 31
..... (duration) 2 yrs. 9 mos. ..... ds.

18. WHERE WAS DISEASE CONTRACTED IF NOT AT PLACE OF DEATH? at place of death
(1) DID AN OPERATION PRECEDE DEATH? No. DATE OF .....
WAS THERE AN AUTOPSY? No
WHAT TEST CONFIRMED DIAGNOSIS? None
(Signed) Frank R. Hudson, 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 Oak Lawn
DATE OF BURIAL 10/4 1928

20. UNDERTAKER C E Routh & Son
ADDRESS Buffalo, Mo.

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.