

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

Do not use this space.

25471

1. PLACE OF DEATH

County Macon Registration District No. 547 File No. _____
 Township Macon Primary Registration District No. 3099 Registered No. 195
 City Hannibal (No. 422 Jefferson) St. 4 Ward _____

2. FULL NAME Margaret Ruth Lovelless

(a) Residence, No. 422 Jefferson St. 4 Ward. (If nonresident, give city or town and State)

Length of residence in city or town where death occurred 20 yrs. 9 mos. 26 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (*write the word*) Divorced
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Delbert Benjamin
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Sept. 8 - 1913
 7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
20 9 26

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. at home
 9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.
 10. Date deceased last worked at this occupation (month and year)
 11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Hannibal Mo.

13. NAME Clarence Lovelless

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Danville Kentucky

15. MAIDEN NAME Ruth Harville

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Hannibal Mo.

17. INFORMANT Ruth Lovelless

18. BURIAL, CREMATION, OR REMOVAL PLACE St. Marys Cemetery DATE July 6 - 1934

19. UNDERTAKER Tom C. Schmitt

(ADDRESS) Hannibal Mo.

20. FILED July 6, 1934 R. S. Schister Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) July 5 - 1934

22. I HEREBY CERTIFY, That I attended deceased from June 12, 1934 to July 4, 1934

I last saw him alive on July 4, 1934. Death is said to have occurred on the date stated above, at 11:30 P.M.

The principal cause of death and related causes of importance were as follows:

Mitral Insufficiency

Other contributory causes of importance:

gr? of? N

Name of operation _____ Date of _____

What test confirmed diagnosis? _____ Was there an autopsy? _____

23. If death was due to external causes (violence), fill in also the following: Accident, suicide, or homicide? _____ Date of injury _____, 19____

Where did injury occur? _____ (Specify city or town, county, and State)
 Specify whether injury occurred in industry, in home, or in public place.

Manner of injury _____

Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased? _____

If so, specify _____

(Signed) H. B. M. Meeker, M. D.

(Address) Hannibal Mo.

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.

AUG 29 1934

