

OCT 19 1937

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

Do not use this space.

1. PLACE OF DEATH

County *Christian*
Township *Bruner*
City (No. *2*)

Registration District No. *185*
Primary Registration District No. *8257*

File No. *33950*
Registered No. _____
St. _____ Ward _____

2. FULL NAME *Iona Loveland*

(a) Residence, No. _____ St. _____ 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 *Female* 4. COLOR OR RACE *white* 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) *widowed*

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) *Feb. 13. 1856*

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, hrs. or min.
	<i>81</i>	<i>7</i>	<i>15</i>	

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. *Housework*

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) *Mo*

13. NAME *Harve Burkhart*

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Ill*

15. MAIDEN NAME *Anna Roberts*

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Ill*

17. INFORMANT *Dr H. J. Wiss*

18. BURIAL, CREMATION, OR REMOVAL PLACE *Boston Cemetery 9 1937*

19. UNDERTAKER *Rickman & Chabbin*

(ADDRESS) *Sparta, Mo.*

20. FILED *10-8* 1937 *Josephine Merritt*

Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) *Sept. 28 . 1937*

22. I HEREBY CERTIFY, That I attended deceased from *Sept 28 1937* to *Sept 28 1937*

I last saw her *did not see her* Death is said to have occurred on the date stated above, at *2:40 p.m.*

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

No diagnosis

Had no physician

Other contributory causes of importance:

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. J. Wiss*, M. D.

(Address) *Sparta, 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.

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