

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

Do not use this space.

3438

1. PLACE OF DEATH

County Maxon Registration District No. 557
 Township Wanna Primary Registration District No. 5745
 City..... (No.) St. Ward)

2. FULL NAME Amanda L. Lovell 640

(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 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) May 30th 1854
 7. AGE YEARS 83 MONTHS 7 DAYS 2 If LESS than 1 day, hrs. or min.

OCCUPATION 8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc.
 9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. Domestic
 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) Ill.

FATHER 13. NAME John Berman

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Ind.

MOTHER 15. MAIDEN NAME Julia Ann Wagner

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Don't know

17. INFORMANT Mrs Frank Zimm
 (ADDRESS) House lady no. 424

18. BURIAL, CREMATION, OR REMOVAL PLACE Union Chapel DATE Jan 3 1938

19. UNDERTAKER Knover & Givan
 (ADDRESS) Hammond Ave.

20. FILED 1-3 1938 Mrs. Alta V. Wagner
 Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Jan 1 1938

22. I HEREBY CERTIFY, That I attended deceased from Dec 19 1937 to Jan 1 1938
 I last saw him alive on Dec 31 1937 Death is said to have occurred on the date stated above, at 1:45 p.m.

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

Chloral turp.
Obstruction of bowels
 Other contributory causes of importance: 40

Name of operation None Date of
 What test confirmed diagnosis? Clinical Was there an autopsy? No

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? No
 If so, specify RTA Park
 (Signed) Hummer M. D.
 (Address) Hammond Ave.

Date of onset
long
time

SSE

RECEIVED

FEB 28 1938

BUREAU OF VITAL STATISTICS
MO. STATE BOARD OF HEALTH

FILL IN ANSWERS TO ALL SPACES
CHECKED IN RED PENCIL.

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

3438

Do not use this space.

1. PLACE OF DEATH

(a) County Marion Registration District No. 552
 (b) Township Warren Primary Registration District No. 5745 Registered No. _____
 (c) City _____ (d) Street No. _____ St. _____
 (If death occurred in Hospital or Institution, write its name instead of street and number)
 (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME Amanda L. Sarrell

(a) Residence, No. _____ St. (Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 7 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) wid

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.
83 7 2

OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.
 9. Industry or business in which work was done, as 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)

FATHER 13. NAME

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

MOTHER 15. MAIDEN NAME

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

17. INFORMANT (ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL

PLACE _____ DATE _____ 19 _____

19. FUNERAL DIRECTOR (ADDRESS)

20. FILED 3-23 19 38 by Mrs. Lyell Searles
R. H. Parker, M.D.
 Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Jan 1, 1938

22. I HEREBY CERTIFY, That I attended deceased from _____ to _____, 19____

I last saw him _____ alive on _____, 19____. Death is said to have occurred on the date stated above, at _____ m.

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

apoptimal tumor
of gall bladder
that originated centrally
but unobstructed
 Date of onset _____

Other contributory causes of importance:
Obstruction of bowel

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) R. H. Parker, M. D.
 (Address) Hunnell Inc

SUPPLEMENTARY

RECIPIENTS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.

S-3438-1938