

NOV 14 1938

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

Do not use this space.

36254

1. PLACE OF DEATH

County Marion Registration District No. 547
Township Wagon Primary Registration District No. 2979
City Hannibal (No. St. Elizabeth Hospital) St. _____ Ward _____

File No. _____
Registered No. 789

2. FULL NAME

(a) Residence, No. 1308 Wagon St. 5 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 W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Oct 24 1938

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
11 0 0 0

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.
10. Date deceased last worked at this occupation (month and year)
11. Total time (years) spent in this occupation

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

FATHER

13. NAME Elmer Lovelace

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

MOTHER

15. MAIDEN NAME Anna Bell Deascol

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

17. INFORMANT Mr. Elmer Lovelace (ADDRESS) Hannibal Mo

18. BURIAL, CREMATION, OR REMOVAL

PLACE Grand Equiburn Park DATE 10-25-1938

19. UNDERTAKER James O'Donnell (ADDRESS) Hannibal Mo

20. FILED Oct 31 1938 St. Elizabeth Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Oct 24 1938

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

I last saw h..... alive on _____, 19____. Death is said to have occurred on the date stated above, at 6:45 p.m.

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

Miscarriage at 5 months. Born dead.

Other contributory causes of importance: Gonorrhoea

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 None

(Signed) O. H. Daniel, M. D.
Address 2272 Broadway

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.

