

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.

APR 11 1940

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

Do not use this space.

1. PLACE OF DEATH

County Callaway Registration District No. 105  
Township Cite Saint James Primary Registration District No. 5161  
City (No. St. Ward)

File No. 6147  
Registered No. 6

2. FULL NAME

Let Margaret Ann Lovells  
(a) Residence, No. St. Ward. (If nonresident, give city or town and State)  
(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.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX <u>Female</u>	4. COLOR OR RACE <u>white</u>	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) <u>unmarried</u>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF		
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) <u>8 9 11 27</u>		
7. AGE	YEARS <u>89</u>	MONTHS <u>11</u>
	DAYS <u>27</u>	IF LESS than 1 day, hrs. or min.
OCCUPATION	8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. <u>housekeeper retired</u>	
	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.	

MOTHER	12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Warren Co. / Illinois</u>
	13. NAME <u>William A. Strickland</u>
FATHER	14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Warren Co. / Illinois</u>
	15. MAIDEN NAME <u>Amanda Strickland</u>
	16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>unknown</u>
	17. INFORMANT (ADDRESS) <u>Margaret Ann Lovells, River View, Missouri</u>
	18. BURIAL, CREMATION, OR REMOVAL PLACE <u>River View</u> DATE <u>2-18</u> 19 <u>40</u>
	19. UNDERTAKER (ADDRESS) <u>Funerary Home, 107 Court Street, Jefferson City, Missouri</u>
	20. FILED <u>2-17</u> 19 <u>40</u> <u>W. Williamson</u> Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 2-16 1940

22. I HEREBY CERTIFY, That I attended deceased from Feb 12 1940, to Feb 16 1940  
I last saw him alive on Feb 16 1940. Death is said to have occurred on the date stated above, at 8:30 a.m.  
The principal cause of death and related causes of importance were as follows:  
Hypostatic pneumonia  
arteriosclerosis  
card. contusions on both legs  
Other contributory causes of importance:  
arteriosclerosis  
card. contusions on both legs

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? Other Date of injury 2-11 1940  
Where did injury occur? House, Jefferson Street  
(Specify city or town, county, and State)  
Specify whether injury occurred in industry, in home, or in public place.  
Home

Manner of injury.....  
Nature of injury.....

24. Was disease or injury in any way related to occupation of deceased?  
If so, specify.....  
(Signed) J. G. Bruce 1, M. D.  
169 (Address) Jefferson City, Mo.



MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

State File No. 6147

Registration District No. 105

Primary Registration District No. 5161

Registrar's No. 6

WRITE PLAINLY--USE UNFADING BLACK INK--MAKE A PERMANENT RECORD

1. PLACE OF DEATH

(a) County Callaway  
(b) City or town Cote Sans Dessein Inc  
(c) Name of hospital or institution:

(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution (Specify whether

In this community years, months or days)

3. (a) PRINCE FULL NAME Margaret Ann Sorrels

3. (b) If veteran, name war 3. (c) Social Security No.

4. Sex 7 5. Color or race w 6. (a) Single, widowed, married, divorced wid

6. (b) Name of husband or wife 6. (c) Age of husband, or wife, if

7. Birth date of deceased Feb. 19 1859  
(Month) (Day) (Year)

8. AGE: Years 89 Months 11 Days 27 If less than one day

9. Birthplace (City, town, or county) (State or foreign country)

10. Usual occupation

11. Industry or business

MOTHER { 12. Name

13. Birthplace (City, town, or county) (State or foreign country)

14. Maiden name

15. Birthplace (City, town, or county) (State or foreign country)

16. (a) Informant

(b) Address

17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)

(c) Place: burial or cremation Reveries

18. (a) Signature of funeral director G. J. Nease  
(b) Address 700 Central Fuller Mo

19. (a) 2-17-1940 (Date received local registrar) (b) C. H. Williamson (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Callaway

(c) City or town Rural Cote Sans Dessein  
(If outside city or town limits write "RURAL")

(d) Street No. (If rural, give location)

(e) If foreign born, how long in U. S. A.? years.

MEDICAL CERTIFICATION

20. DATE OF DEATH Month 2 day 16  
year 1940 hour minute M.

21. I hereby certify that I attended the deceased from 19 to 19  
and that death occurred on the date and hour stated above.

Immediate cause of death

Due to

Due to

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations

Of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify)

(b) Date of occurrence

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?

While at work? (Specify type of place) (e) Means of injury

23. Signature J. B. Bruce (M. D. or other)

Address Jefferson City Mo Date signed

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

SUPPLEMENTAL

