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

PLACE OF DEATH

County Ray

Township ~~Richmond~~

or Village

or City Henrietta, (NO. ..... St.; ..... Ward)

Registration District No. 741

Primary Registration District No. 4443

File No. 25 27110

Registered No.

[If death occurred in a hospital or institution, give its NAME instead of street and number]

FULL NAME Marvin Lovell

PERSONAL AND STATISTICAL PARTICULARS

SEX	COLOR OR RACE	SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)
Male	White	

DATE OF BIRTH March 2, 1912 (Month) (Day) (Year)

AGE 1 yrs. 8 mos. 2 ds. If LESS than 1 day, ... hrs. or ..... min.?

OCCUPATION
(a) Trade, profession, or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

BIRTHPLACE (City or town, State or foreign country) Henrietta, Mo.

PARENTS

NAME OF FATHER George Lovell

BIRTHPLACE OF FATHER (City or town, State or foreign country) Norborne, Mo.

MAIDEN NAME OF MOTHER Ida Alice Wade

BIRTHPLACE OF MOTHER (City or town, State or foreign country) Henrietta, Mo.

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) George Lovell

(ADDRESS) Henrietta, Mo

Filed Aug 1 - 1914. G.W. Smith REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH July (Month) 30 (Day), 1914 (Year)

I HEREBY CERTIFY, that I attended deceased from July 7 -, 1914, to July-30, 1914, that I last saw h~~im~~ alive on July 30, 1914, and that death occurred, on the date stated above, at 5: P. m.

The CAUSE OF DEATH* was as follows:

Cholera Infantum

11 1/2 A

10 4

(Duration) ..... yrs. ..... mos. ..... ds.

Contributory (SECONDARY) —

(Duration) 0 yrs. ..... mos. ..... ds.

(Signed) G.W. Smith M. D.

July-30, 1914 (Address) Henrietta, Mo

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted if not at place of death?

Former or usual residence

PLACE OF ~~BURIAL~~ OR REMOVAL	DATE OF BURIAL
Norborne	July-31, 1914
UNDERTAKER G.R. Sinnett	**ADDRESS** Richmond

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.

MISSOURI STATE BOARD OF HEALTH
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CERTIFICATE OF DEATH

PLACE OF DEATH

County.....

Township ..... Registration District No. ..... File No. .....
or
Village ..... Primary Registration District No. ..... Registered No. .....
or
City ..... (NO. ....., ... St.; ..... Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number]

FULL NAME .....

PERSONAL AND STATISTICAL PARTICULARS

SEX	COLOR OR RACE	SINGLE MARRIED WIDOWED OR DIVORCED (*Write* the word)

DATE OF BIRTH

....., *I*.....
(Month) (Day) (Year)

AGE

.....yrs. .....mos. .....ds.

If LESS than 1 day, ...hrs. or .....min.?

OCCUPATION
(a) Trade, profession, or particular kind of work .....

(b) General nature of industry, business, or establishment in which employed (or employer) .....

BIRTHPLACE
(City or town, State or foreign country)

PARENTS

NAME OF FATHER

BIRTHPLACE OF FATHER
(City or town, State or foreign country)

MAIDEN NAME OF MOTHER

BIRTHPLACE OF MOTHER
(City or town, State or foreign country)

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant).....

(ADDRESS).....

Filed ....., 191....., ...
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH

....., *191*.....
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from ....., 191....., to ....., 191....., that I last saw h..... alive on ....., 191....., and that death occurred, on the date stated above, at .....m.

The CAUSE OF DEATH* was as follows:

.....

.....

.....

.....(Duration).....yrs. .....mos. .....ds.

Contributory
(SECONDARY)
.....(Duration).....yrs. .....mos. .....ds.

(Signed)..... M. D.

....., 191..... (Address).....

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death.....yrs. .....mos. .....ds. In the State.....yrs. .....mos. .....ds.

Where was disease contracted if not at place of death? .....

Former or usual residence.....

PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL ....., 191.....
UNDERTAKER	ADDRESS

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.