

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

PLACE OF DEATH

County Wagon Registration District No. 1002 File No. 35491
Township Independence or Village _____ Primary Registration District No. 5701 Registered No. 4
City _____ (NO. _____) St. _____ Ward _____

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

FULL NAME Lois Hiatt

PERSONAL AND STATISTICAL PARTICULARS

SEX <u>Female</u>	COLOR OR RACE <u>White</u>	SINGLE MARRIED WIDOWED OR DIVORCED (Write the word)
DATE OF BIRTH _____, 190 <u>2</u> (Month) (Day) (Year)		
AGE <u>9</u> yrs. _____ mos. _____ ds.		IF LESS than 1 day, _____ hrs. or _____ min.?
OCCUPATION (a) Trade, profession, or particular kind of work <u>James child</u> (b) General nature of industry, business, or establishment in which employed (or employer) _____		
BIRTHPLACE (City or town, State or foreign country) <u>Iowa</u>		
PARENTS	NAME OF FATHER <u>William O Hiatt</u>	
	BIRTHPLACE OF FATHER (City or town, State or foreign country) <u>Iowa</u>	
	MAIDEN NAME OF MOTHER <u>Flora Main</u>	
	BIRTHPLACE OF MOTHER (City or town, State or foreign country) <u>Iowa</u>	

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Oct 2, 1911
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Aug, 1908 to Oct 1, 1911, that I last saw her alive on Oct 1, 1911, and that death occurred, on the date stated above, at 4 1/2 p.m.
The CAUSE OF DEATH was as follows:
Diabetic Coma

Contributory Diabetes Mellitus
(SECONDARY) (Duration) _____ yrs. _____ mos. _____ ds.
(Signed) J. P. Foster M. D.
(Address) Loerose 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 Steele Cemetery DATE OF BURIAL _____ 1911

UNDERTAKER J. C. Cober ADDRESS Atlanta

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) J. G. Hiatt

(ADDRESS) Atlanta Mo

Filed Oct 4, 1911 J. S. Mathis
REGISTRAR

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

Revised United States Standard Certificate of Death

[Approved by U. S. Census and American Public Health
Association]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcinoma*, *Sar-*

coma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicaemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)



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BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

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

PLACE OF DEATH Macou
 County Independence Registration District No. 1002 File No. 4
 or Independence Primary Registration District No. 5701 Registered No. 4
 Village _____
 .or _____
 City _____ (NO. _____ St. _____ Ward _____)

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

FULL NAME Lois Hiatt

PERSONAL AND STATISTICAL PARTICULARS

SEX Female COLOR OR RACE white SINGLE MARRIED WIDOWED OR DIVORCED Single
(Write the word)

DATE OF BIRTH _____ (Month) _____ (Day) 902 (Year)

AGE 9 yrs. _____ mos. _____ ds. IF LESS than 1 day, _____ hrs. or _____ min.

OCCUPATION (a) Trade, profession, or particular kind of work None
 (b) General nature of industry, business, or establishment in which employed (or employer) Farmer's child

BIRTHPLACE (City or town, State or foreign country) Iowa

PARENTS
 NAME OF FATHER Wm. Hiatt
 BIRTHPLACE OF FATHER (City or town, State or foreign country) Iowa
 MAIDEN NAME OF MOTHER Stora Mann
 BIRTHPLACE OF MOTHER (City or town, State or foreign country) Iowa

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
 (Informant) N. O. Hiatt
 (ADDRESS) Atlanta Mo

Filed Oct 4 1917 J. S. McKee REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Oct 2, 1917
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from _____, 19108 to Oct 1, 1917, that I last saw her alive on Oct 1, 1917, and that death occurred, on the date stated above, at 4A m.

The CAUSE OF DEATH* was as follows:
Diabetic coma

Contributory Diabetic mellitus
(SECONDARY) (Duration) _____ yrs. _____ mos. _____ ds.

(Signed) J. P. Foster M. D.
Oct 3, 1917 Address Lacrosse 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 Steele Cem DATE OF BURIAL Oct 7, 1917
 UNDERTAKER J. C. Carter ADDRESS Atlanta Mo

Revised United States Standard Certificate of Death

[Approved by U. S. Census and American Public Health
Association]

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