

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

PLACE OF DEATH

County Jasper

Township _____

Village _____

City Joplin

Registration District No. 411

Primary Registration District No. 2002

(NO. East 20 St.: _____ Ward)

File No. 13439

Registered No. 183

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

FULL NAME

Hattie M. Hatley

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

SEX

COLOR OR RACE

SINGLE
MARRIED
OR DIVORCED
(Write the word)

Female

White

Married

DATE OF DEATH

Apr. 15, 1913
(Month) (Day) (Year)

DATE OF BIRTH

Jan. 7, 1870
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Apr. 12, 1913, to Apr. 15, 1913,

that I last saw her alive on Apr. 12, 1913,

and that death occurred, on the date stated above, at 6⁴⁵ a.m.

AGE

43 yrs. 3 mos. 8 ds. If LESS than 1 day, ___ hrs. or ___ min.?

The CAUSE OF DEATH* was as follows:

Mercuric Poisoning

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

Housewife

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

None

BIRTHPLACE
(City or town, State or foreign country)

Mo.

Contributory (Secondary)

Dropsy
(Duration) ___ yrs. ___ mos. ___ ds.

NAME OF FATHER

R. Elliott

(Signed)

Dr. W. W. ... M. D.

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

Mo.

Apr. 15, 1913 (Address) Joplin, Mo.

MAIDEN NAME OF MOTHER

Jane Watkins

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

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

Mo.

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

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

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Elija H. Hatley

Where was disease contracted if not at place of death?

Former or usual residence

(ADDRESS)

Joplin, Mo.

PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Laginaw, Mo.

Apr. 15, 1913

Filed

4-5

1913

A.M. Gregg

REGISTRAR

UNDERTAKER

Frank ... Undertaking Co.

ADDRESS

J. P. ... Joplin, Mo.

No. CAUSALITY. Exact statement of OCCUPATION, if 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*, *Composer*, *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*, *Sarcoma*, 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 septicæmia," "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.)

N. B. - If information should be carefully supplied. AGE should be stated in full years, months and days. PHYSICIANS should state hospital or institution where death occurred. If death occurred in a hospital or institution, give its NAME instead of street and number.

PLACE OF DEATH

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS

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

CERTIFICATE OF DEATH

County Jasper Registration District No. 411 File No. _____
 Township _____ or Village _____ Primary Registration District No. 2002 Registered No. 182
 City Joplin (NO. East 20 St. _____ Ward _____)
 FULL NAME Nattie M. Hatley

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

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

SEX F COLOR OR RACE W SINGLE MARRIED WIDOWED OR DIVORCED (If write the word) m.
 DATE OF BIRTH Jan. 7 - 1870
 (Month) (Day) (Year)
 AGE 43 yrs. 3 mos. 8 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) _____
 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) _____

DATE OF DEATH April 15, 1913
 (Month) (Day) (Year)
 I HEREBY CERTIFY, that I attended deceased from Apr. 12, 1913, to Apr. 15, 1913,
 that I last saw her alive on 4-12, 1913,
 and that death occurred, on the date stated above, at 6:45 a.m.
 The CAUSE OF DEATH* was as follows:
Uremic Poisoning
 Contributory Dropsy - Nephritis
 (Signed) [Signature] M. D.
4-15-13 (Address) Joplin Mo.

Satisfactory Information Supplied.
SUPPLEMENTARY
 Satisfactory Information Supplied.

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
 (Informant) Satisfactory Information Supplied.
 (ADDRESS) _____

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)
 At place of death _____ yrs. _____ mos. _____ ds. In the _____ yrs. _____ mos. _____ ds.
 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 _____ 1913
 UNDERTAKER Satisfactory Information Supplied. ADDRESS _____

Revised United States Standard Certificate of Death

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

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