MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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.

V. S. No. 2.

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

PLACE OF DEATH

County: Nodaway

Township: Nodaway

or Village:

or City: ~~Burlington Jc Mo~~ (No.: , St.: , Ward)

Registration District No. 618 File No. 36951

Primary Registration District No. 5820 Registered No.

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

FULL NAME Sarah J. Hackett.

PERSONAL AND STATISTICAL PARTICULARS

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

DATE OF BIRTH: July (Month) 7 (Day), 1834 (Year)

AGE: 79 yrs. 3 mos. 24 ds. If LESS than 1 day, hrs. or min.?

OCCUPATION
(a) Trade, profession, or particular kind of work: Housekeeper
(b) General nature of industry, business, or establishment in which employed (or employer): X

BIRTHPLACE (City or town, State or foreign country): N.Y.

PARENTS
NAME OF FATHER: Pettibone
BIRTHPLACE OF FATHER (City or town, State or foreign country): Unknown
MAIDEN NAME OF MOTHER: Unknown
BIRTHPLACE OF MOTHER (City or town, State or foreign country): Unknown

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) E. E. Hackett

(ADDRESS) Burl Jc Mo

Filed Nov 4 1913 O. L. Dean REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH: Oct (Month) 31 (Day), 1913 (Year)

I HEREBY CERTIFY, that I attended deceased from Oct 31, 1913, to Oct 31, 1913, that I last saw her alive on Oct 31, 1913, and that death occurred, on the date stated above, at 7 a.m.

The CAUSE OF DEATH* was as follows:

1 Fatty Degeneration of Heart (Found dead in bed)

(Duration) yrs. mos. ds.

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

(Signed) O. L. Dean M. D.

Oct 31, 1913 (Address) Burl Jc 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
Chillicothe Mo	Nov 3, 1913
UNDERTAKER	**ADDRESS**
T. E. Forsyan	Burl Jc Mo

Revised United States Standard Certificate of Death

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

MISSOURI STATE BOAR
BUREAU OF VITAL ST
CERTIFICATE OF DE

PLACE OF DEATH

County Nodaway

Township Nodaway — Registration District No. _____ File No. _____

or

Village of [illegible] — Primary Registration District No. _____ Registered No. _____

or

City _____ (NO. _____ St.; _____ Ward)

FULL NAME Amanda [illegible]

PERSONAL AND STATISTICAL PARTICULARS

SEX	COLOR OR RACE	~~SINGLE~~ MARRIED ~~WIDOWED~~ ~~OR DIVORCED~~ (Write the word)
[illegible]	[illegible]	married

DATE OF BIRTH June (Month) 12 (Day), 1918 (Year)

AGE 75 yrs. _____ mos. _____ ds. — If LESS than 1 day, ____ hrs. or ____ min.?

OCCUPATION
(a) Trade, profession, or particular kind of work [illegible]
(b) General nature of industry, business, or establishment in which employed (or employer) _____

BIRTHPLACE (City or town, State or foreign country) [illegible]

PARENTS

NAME OF FATHER [illegible]

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

MAIDEN NAME OF MOTHER [illegible]

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

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Nancy [illegible]

(ADDRESS) [illegible] Ills

Filed [illegible], 1918, _____ REGISTRAR

MEDICAL CERTIFICATE OF DE

DATE OF DEATH _____ (Month)

I HEREBY CERTIFY, that I atten _____, 191__, to _____ that I last saw h_____ alive on _____ and that death occurred, on the date stated a The CAUSE OF DEATH* was as follows:

_____ (Duration) _____ yrs. _____

Contributory (SECONDARY) _____ (Duration) _____ yrs. _____

(Signed) _____

_____, 191__ (Address) _____

*State the Disease Causing Death, or, in deaths fro (1) Means of Injury; and (2) whether Accidental, Suicidal, or

LENGTH OF RESIDENCE (FOR HOSPITALS INSTITUTI RECENT RESIDENTS)

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

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

Former or usual residence _____

PLACE OF BURIAL OR REMOVAL	DATE
UNDERTAKER	ADDR