

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

PLACE OF DEATH

County Fels

Township _____

or _____

Village _____

or _____

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

Registration District No. 685

File No. 5-2039

Primary Registration District No. 4409

Registered No. 3

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

FULL NAME Carrene Pickett Hawatt

PERSONAL AND STATISTICAL PARTICULARS

SEX <u>male</u>	COLOR OR RACE <u>white</u>	SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) <u>Single</u>
DATE OF BIRTH <u>July 2</u> , 1903 (Month) (Day) (Year)		
AGE <u>10</u> yrs. <u>8</u> mos. <u>22</u> ds.		If LESS than 1 day, ___ hrs. or ___ min.?
OCCUPATION (a) Trade, profession, or particular kind of work <u>Child</u>		
(b) General nature of industry, business, or establishment in which employed (or employer) <u>at home</u>		

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH
January - 24, 1914
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Jan - 24, 1914, to Jan - 24, 1914, that I last saw him alive on Jan - 24, 1914, and that death occurred, on the date stated above, at 5:18 m.

The CAUSE OF DEATH* was as follows:
Capillary hemorrhage following an accidental wound

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

PARENTS	NAME OF FATHER <u>Alexander Hawatt</u>
	BIRTHPLACE OF FATHER (City or town, State or foreign country) <u>Scotland</u>
	MAIDEN NAME OF MOTHER <u>Lena Moulster</u>
	BIRTHPLACE OF MOTHER (City or town, State or foreign country) <u>Wisconsin</u>

(Duration) ___ yrs. ___ mos. ___ ds.
Contributory Hemophilia
(SECONDARY) (Duration) 10 yrs. 8 mos. 22 ds.

(Signed) E M Bartlett M. D.
Jan - 24, 1914 (Address) Clarksville Mo

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Alexander Hawatt
(ADDRESS) Clarksville

*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 _____

Filed Jan 25, 1914, W W Sweeney
REGISTRAR

PLACE OF BURIAL OR REMOVAL <u>Clarksville</u>	DATE OF BURIAL <u>4/26</u> , 191 <u>4</u>
UNDERTAKER <u>W J Duncan</u>	ADDRESS <u>Clarksville</u>

N. B.—Every item of information should be carefully supplied, and 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.

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 *Houskeepers* 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*, *peritonaeum*, 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.)

HUGH STEPHENS, JEFFERSON CITY.



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

PLACE OF DEATH

County

Pike

Township

Registration District No.

685

File No.

Village

Primary Registration District No.

4409

Registered No.

3

City

Clarksville MO

St.

Ward

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

FULL NAME

Clarence Robert Hawatt

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

SEX

COLOR OR RACE

SINGLE
MARRIED
WIDOWED
OR DIVORCED
(Write the word)

M

W

S

DATE OF DEATH

Jan 24, 191*4*

(Month)

(Day)

(Year)

DATE OF BIRTH

(Month)

(Day)

1

(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 *5 1/2 P.M.*

The CAUSE OF DEATH* was as follows:

Shells Leumlog following an accident, wound caused by discharge of Toy pistol that "wasn't loaded"
(Duration) _____ yrs _____ mos _____ ds.

Contributory

Neurophilia

(SECONDARY)

(Duration)

1 yrs. 8 mos. 22 ds.

(Signed)

Geo. Porter

(Address)

Clarksville Mo

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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

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(ADDRESS)

Filed

1/25

191____

W. W. Railway

REGISTRAR

Original file, date *JAN - 1914*

All information called for must be written on this Supplementary Certificate.

CAUSE OF DEATH in plain language. Information. PHYSICIANS should state EXACTLY. OCCUPATION is very important.

AGE. Satisfactory Information Supplied. PARENTS. BIRTHPLACE OF FATHER. MAIDEN NAME OF MOTHER. BIRTHPLACE OF MOTHER.

SUPPLEMENTARY INFORMATION SUPPLIED.

SEAL. I HEREBY CERTIFY.

Revised United States Standard Certificate of Death

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

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2039

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