

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

PLACE OF DEATH

County Ray
Township Fishing River
or
Village _____
or
City _____ (NO. _____ St.: _____ Ward _____)

Registration District No. 743
Primary Registration District No. 6237

File No. 30099
Registered No. 27

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

FULL NAME Eliza A. Hackett

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

SEX Female COLOR OR RACE White SINGLE MARRIED WIDOWED OR DIVORCED (If write the word) Widowed
DATE OF BIRTH June 12, 1834
(Month) (Day) (Year)
AGE 75 yrs. 3 mos. 3 ds. If LESS than 1 day, ___ hrs. or ___ min.?

DATE OF DEATH Sept. 15, 1914
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Sept 6th, 1914, to Sept 15, 1914, that I last saw her alive on Sept 14, 1914, and that death occurred, on the date stated above, at 7 a.m.

The CAUSE OF DEATH* was as follows
Cerebral Hemorrhage

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

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

PARENTS NAME OF FATHER Wm Edward
BIRTHPLACE OF FATHER (City or town, State or foreign country) Dont know
MAIDEN NAME OF MOTHER Dont know
BIRTHPLACE OF MOTHER (City or town, State or foreign country) Dont know

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

(Signer) C. F. Isley M. D., Sept 15, 1914 (Address) Excelsior Springs 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 75 yrs. 3 mos. 3 ds. State 75 yrs. 3 mos. 3 ds.
Where was disease contracted if not at place of death? _____
Former or usual residence Rich Hill Mo.

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Roy R. Hackett.
(ADDRESS) Excelsior Springs Mo.

PLACE OF BURIAL OR REMOVAL Rich Hill Mo. DATE OF BURIAL Sept. 16, 1914
UNDERTAKER E. E. Endow ADDRESS Excelsior Springs Mo.

Filed Sept 16 1914. L. E. Ellis REGISTRAR

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.

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 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.)

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

PLACE OF DEATH
 County Ray
 Township Fishing River
 or
 Village _____
 or
 City _____

Registration District No. 743 File No. _____
 Primary Registration District No. 6237 Registered No. 27
 NO. _____ St. _____ Ward _____

FULL NAME Eliza A. Hackett
 (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
 (Write the word)

DATE OF DEATH Sept. 15 1914
 (Month) (Day) (Year)

DATE OF BIRTH _____
 (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from _____, 191____ to _____, 191____
 that I last saw h. _____, 191____

AGE _____
 If LESS than 1 day, _____ hrs. _____ min. _____ ds.
 yrs. mos. ds.

and that death occurred, on the date stated above at _____ m.
 The CAUSE OF DEATH* was as follows:

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

Central Hemorrhage
64
 (Duration) _____ yrs. _____ mos. _____ ds.

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

Contributory arterio sclerosis
 (SECONDARY)
 (Duration) _____ yrs. _____ mos. _____ ds.

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) _____

(Signed) C. J. Salter M. D.
1915 1914 (Address Excelsior Spgs Mo.)

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
 (Informant) _____

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

(ADDRESS) _____

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)
 At place of death _____ yrs. _____ mos. _____ ds. State _____ yrs. _____ mos. _____ ds.
 Where was disease contracted If not at place of death? _____

Filed _____ 191____
 REGISTRAR _____

Former or usual residence _____

PLACE OF BURIAL OR REMOVAL _____ DATE OF BURIAL _____ 191____

UNDERTAKER _____ ADDRESS _____

SATISFACTORY INFORMATION SUPPLIED
 SUPPLEMENTARY
 SATISFACTORY INFORMATION SUPPLIED

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30099

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