

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

24393

1. PLACE OF DEATH

County Harrison
Township Clinton
City Clinton

Registration District No. 352
Primary Registration District No. 3015

File No. 24393
Registered No. 1529
St. Mo. Ward

2. FULL NAME

Harriet Cooper Hatfield

(a) Residence No. St. Ward
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. da. How long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)

Female White

5A. IF MARRIED, WIDOWED, OR DIVORCED
HUSBAND OF
(OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR)

1-26-1905

7. AGE

YEARS

MONTHS

DAYS

IF LESS than 1
day, hrs. min.

15

6

15

8. OCCUPATION OF DECEASED

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

Laborer

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

0

(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN)

Fortune

(STATE OR COUNTRY)

Missouri

10. NAME OF FATHER

J. D. Hatfield

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY)

Missouri

12. MAIDEN NAME OF MOTHER

Nancy Fowler

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY)

Missouri

14.

INFORMANT
(Address)

J. D. Hatfield
Clinton Mo

15.

FILED

2/14 1920

B. A. Barr
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

15. DATE OF DEATH (MONTH, DAY AND YEAR)

July 11 1920

17.

I HEREBY CERTIFY, That deceased died on

July 12, 1920, and that death occurred on the date stated above.

THE CAUSE OF DEATH* WAS AS FOLLOWS

according to the coroner's jury as a result of being struck by an freight train

CONTRIBUTORY (SECONDARY)

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH

DID AN OPERATION PRECEDE DEATH

WAS THERE AN AUTOPSY

WHAT TEST CONFIRMED DIAGNOSIS

(Signed)

W. J. Jennings, M.D.
Clinton Mo.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. (See reverse side for additional space.)

19. PLACE OF BURIAL, CREMATION, OR REMOVAL

DATE OF BURIAL

Clinton Mo

2/14 1920

20. UNDERTAKER

Clinton Mo

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.

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1. PLACE OF DEATH

County..... File No.....
Township..... Registered No.....
City..... (No.)..... St. Ward)

2. FULL NAME

(a) Residence. No..... St. Ward.....
(Usual place of abode)
Length of residence in city or town where death occurred yrs. mos. da. (If nonresident give city or town and State)
da. mos. da. (If of foreign birth? yrs. mos. da.)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX..... 4. COLOR OR RACE..... 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR)

7. AGE YEARS MONTHS DAYS IF LESS THAN 1 day, hrs. or min.

8. OCCUPATION OF DECEASED

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

9. BIRTHPLACE (CITY OR TOWN)..... (STATE OR COUNTRY)

10. NAME OF FATHER.....

11. BIRTHPLACE OF FATHER (CITY OR TOWN)..... (STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER.....

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)..... (STATE OR COUNTRY)

14. INFORMANT (Address)

15. FILED....., 19.....

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR)..... 19.....

17. I HEREBY CERTIFY, That I attended deceased from..... to....., 19....., and that I last saw him alive on....., 19....., and that death occurred, on the date stated above, at.....
THE CAUSE OF DEATH* WAS AS FOLLOWS:

CONTRIBUTORY (SECONDARY)

(duration)..... yrs. mos. da.

(duration)..... yrs. mos. da.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH.....

DID AN OPERATION PRECEDE DEATH..... DATE OF.....

WAS THERE AN AUTOPSY.....

WHAT TEST CONFIRMED DIAGNOSIS.....

(Signed)....., M. D.
....., 19..... (Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. (See reverse side for additional space.)

19. PLACE OF BURIAL, CREMATION, OR REMOVAL DATE OF BURIAL

20. UNDERTAKER ADDRESS