

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

11524

1. PLACE OF DEATH

County Saline Registration District No. 792 File No. _____
 Township Arrow Rock Primary Registration District No. 4131 Registered No. _____
 City Nelson (No. 6035 St. _____ Ward _____)

2. FULL NAME Wm. Immanuel Hatcher

(a) Residence No. _____ St. _____ Ward _____
 (Usual place of abode) (If nonresident give city or town and State)
 Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

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

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Oct. 17, 1922

6. DATE OF BIRTH (MONTH, DAY AND YEAR) _____
 7. AGE YEARS MONTHS DAYS If LESS than 1 day, ____ hrs. or ____ min.
4 16

8. OCCUPATION OF DECEASED
 (a) Trade, profession, or particular kind of work None
 (b) General nature of industry, business, or establishment in which employed (or employer) _____
 (c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN) Blackwater Mo
 (STATE OR COUNTRY) Missouri

10. NAME OF FATHER Leonard Hatcher

11. BIRTHPLACE OF FATHER (CITY OR TOWN) Near Nelson
 (STATE OR COUNTRY) Daviess Co. Mo.

12. MAIDEN NAME OF MOTHER Florence Johnson

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) _____
 (STATE OR COUNTRY) Cooper Co. Mo.

14. INFORMANT Leonard Hatcher
 (Address) Blackwater

15. FILED 3-6-23 1923 M. J. Brady
 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Mar 5th 1923

17. I HEREBY CERTIFY, That I attended deceased from Mar 4th 1923 to Mar 5th 1923
 that I last saw him alive on Mar 4th 1923, and that death occurred, on the date stated above, at 12 m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Influenza
1113 (duration) yrs. mos. 4 ds.

CONTRIBUTORY (SECONDARY) 110 (duration) yrs. mos. ds.

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. J. Brady, H. B.
 , 19 (Address) Blackwater, 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 Nelson Cemetery DATE OF BURIAL March 6, 1923

20. UNDERTAKER L. M. Nelson ADDRESS Nelson, Mo.

PARENTS

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," "Anomia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicemia," "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.)

NOTE.—Individual offices may add to above list of undesirable terms and refuse to accept certificates containing them. Thus the form in use in New York City states: "Certificates will be returned for additional information which give any of the following diseases, without explanation, as the sole cause of death: Abortion, cellulitis, childbirth, convulsions, hemorrhage, gangrene, gastritis, erysipelas, meningitis, miscarriage, necrosis, peritonitis, phlebitis, pyemia, septicemia, tetanus." But general adoption of the minimum list suggested will work vast improvement, and its scope can be extended at a later date.

ADDITIONAL SPACE FOR FURTHER STATEMENTS
BY PHYSICIAN.

STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

1 PLACE OF DEATH
 County Ladine State MISSOURI Registered No. _____
 Township Arrow Rock or Village 6035 _____ or
 City _____ No. _____ St. _____ Ward _____
(If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Wm Emmanuel Hincher
 (a) Residence. No. _____ St. _____ Ward _____
(Usual place of abode)
 Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3 SEX M **4 COLOR OR RACE** B **5 SINGLE, MARRIED, WIDOWED, OR DIVORCED** single
(write the word)

16 DATE OF DEATH (month, day, and year) Mar 5 1923

5a If married, widowed, or divorced
 HUSBAND of _____
 (or) WIFE of _____

17 I HEREBY CERTIFY, That I attended deceased from _____, 19____, to _____, 19____, that I last saw him alive on _____, 19____, and that death occurred, on the date stated above, at _____ m.

6 DATE OF BIRTH (month, day, and year) Oct 17 - 1922

7 AGE
 Years _____ Months 4 Days 16
 IF LESS than 1 day, --- hrs. or --- min.

The **CAUSE OF DEATH*** was as follows:
Influenza

8 OCCUPATION OF DECEASED

CONTRIBUTORY (SECONDARY) _____ (duration) _____ yrs. _____ mos. _____ ds.

(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 _____

18 Where was disease contracted _____ (duration) _____ yrs. _____ mos. _____ ds.
 If not at place of death? _____

9 BIRTHPLACE (city or town) Blackwater
 (State or country) Mo.

Did an operation precede death? _____ Date of _____

10 NAME OF FATHER Leonard Hincher

Was there an autopsy? _____

11 BIRTHPLACE OF FATHER (city or town) _____ (State or country) Mo.

What test confirmed diagnosis? _____

12 MAIDEN NAME OF MOTHER Florence Johnson

(Signed) W. J. Abney, M. D.
 , 19 (Address) Blackwater

13 BIRTHPLACE OF MOTHER (city or town) _____ (State or country) 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.)

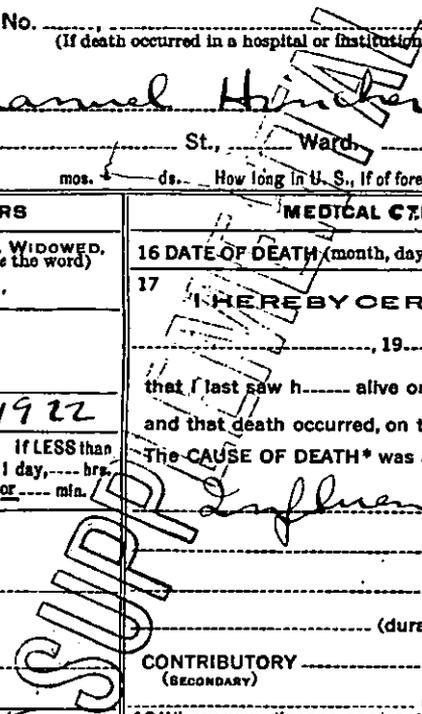
14 Informant Leonard Hincher
 (Address) _____

19 PLACE OF BURIAL, CREMATION, OR REMOVAL Nelson Cem. **DATE OF BURIAL** Mar 6 - 1923

15 Filed 5/12, 1923 M. S. McQuinn
 REGISTRAR

20 UNDERTAKER L. M. Nelson **ADDRESS** Nelson

TION is very important. See instructions on back of certificate.



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