AUG 17 1927

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

Do not use this space.

21866

File No. .....

Registered No. 32

1. PLACE OF DEATH

County: Lawrence — Registration District No. 477

Township: Lawrence — Primary Registration District No. 5641

City ..... (No. ..... St. ..... Ward)

2. FULL NAME: Hester Viola Hackstel

(a) Residence. No. ..... St., ..... Ward, ..... (If nonresident give city or town and State)
(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.

## PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: white

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

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR): May 6 1903

7. AGE: Years 24 | Months 2 | Days 13 | If LESS than 1 day, ..... hrs. or ..... min.

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

9. BIRTHPLACE (CITY OR TOWN): Camp Point
(STATE OR COUNTRY): Illinois

PARENTS

10. NAME OF FATHER: Edward Valeu

11. BIRTHPLACE OF FATHER (CITY OR TOWN) .....
(STATE OR COUNTRY): Lewis Co. Mo.

12. MAIDEN NAME OF MOTHER: Minnie Peterson

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

14. INFORMANT: Mrs James Bragg
(Address): Carthage Mo

15. FILED 7-20 1927 H. W. Harris, REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR): July 19 1927

17. I HEREBY CERTIFY, That I attended deceased from July 14, 1927, to July 19, 1927, that I last saw her alive on July 19, 1927, and that death occurred, on the date stated above at 7 P. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Acute-Bronchitis.
2 3/4
2 2/7
1 3/6
(duration) ..... yrs. ..... mos. 6 ds.

CONTRIBUTORY (SECONDARY): Strepto Coccus
Abscess of Lung (duration) 12 yrs. ..... mos. ..... ds.

18. WHERE WAS DISEASE CONTRACTED IF NOT AT PLACE OF DEATH? Place of death.

DID AN OPERATION PRECEDE DEATH? no DATE OF .....

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS? Symptoms

(Signed) Geo. McCutchan, M. D.

7-20, 1927 (Address) Carlton 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: Forest Green Cem. — DATE OF BURIAL: 7/21 1927

20. UNDERTAKER: Earl H. Bailey — ADDRESS: Carthage Mo.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION 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 *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 neoplasm); *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," "Anemia" (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.

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

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

**1. PLACE OF DEATH**

County Lewis — Registration District No. 477 — File No.

Township Canton — Primary Registration District No. 5641 — Registered No. 32

City ..... (No. ..... St. ..... Ward)

**2. FULL NAME** Vesta Viola Hachtel

(a) Residence. No. ..... St., ..... Ward. ..... (If nonresident give city or town and State)
(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.

**PERSONAL AND STATISTICAL PARTICULARS**

| 3. SEX | 4. COLOR OR RACE | 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write* the word) |
|---|---|---|
| F | W | M |

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)

PARENTS

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 Sept 15, 1927 L. Lee Harris
REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) July 19 1927

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

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Acute Bronchitis
Tuberculous Abscess
..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (SECONDARY) Streptococcus abscess
Lung (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. 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.

| 19. PLACE OF BURIAL, CREMATION, OR REMOVAL | DATE OF BURIAL 19 |
|---|---|
| 20. UNDERTAKER | ADDRESS |

SUPPLEMENTARY

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N. B.—[illegible] should be carefully supplied. AGE should be stated EXACTLY. [illegible] SICIANS [illegible] CAUSE OF D[illegible] in plain [illegible], so that it may be properly classified. Exact statement of OCCUPATION is [illegible]

REGISTRARS SHALL NOT [illegible] E A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS F[illegible]

# BOARD OF HEALTH
## VITAL STATISTICS
### CERTIFICATE OF DEATH

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**1. PLACE OF DEATH**

County .....

Township .....

City .....

(Ward) .....

**2. FULL NAME** .....

(a) Residence. If residence is city or town where decedent resided (Street and number or place of abode) ..... No. ..... Ward.

(b) Usual place of abode (if different from above) ..... No. ..... Ward.

**3. SEX** ..... **4. COLOR OR RACE** ..... **5. MARITAL STATUS** ..... **6. DATE OF BIRTH** (Month, day and year) .....

**7. AGE** Years ..... Months ..... Days ..... If less than 1 day, hrs. ..... min. .....

**8. OCCUPATION OF DECEDENT**

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

(b) General nature of 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 .....

**MEDICAL CERTIFICATE OF DEATH**

**16. DATE OF DEATH** (Month, day and year) ..... 19 .....

I HEREBY CERTIFY, That I attended deceased from ..... 19 ..... to ..... 19 ..... and that death occurred, on the date stated above, at .....

THE CAUSE OF DEATH* was as follows:

.....

.....

.....

.....

.....

**17. CONTRIBUTORY (SECONDARY)** ..... (duration) ..... yrs. ..... mos. ..... dys.

**18. WHERE WAS DISEASE CONTRACTED** ..... (duration) ..... yrs. ..... mos. ..... dys.

IF NOT AT PLACE OF DEATH .....

**19. DID AN OPERATION PRECEDE DEATH?** ..... **DATE OF** .....

WAS THERE AN AUTOPSY? .....

WHAT TEST CONFIRMED DIAGNOSIS? .....

(Signed) ..... (Address) ..... M.D.

*State the Disease Causing Death, or in default thereof, the Symptom or Injury, and the Nature of Accident, Suicide or Homicide.

(1) Means and Nature of Injury, and (2) weight of a child under one year, state whether born alive or stillborn.

**SEXTON** **REGISTRAR**

**SSSSDDY** **DUNCAN DOE**

**19 PLACE OF BURIAL, REMOVAL OR CREMATION, JAMAICA, L.I.**

**II. 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.**