JAN 17 1928

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

Do not use this space.

36068

1. PLACE OF DEATH

County Buchanan — Registration District No. 85 — File No.

Township — Primary Registration District No. 1001 — Registered No. 1311

City St. Joseph, (No. St. Joseph's Hospital St. Ward)

2. FULL NAME Ada Hackett

(a) Residence. No. St., Ward. Lawson, Mo.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 1 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: William T. Hackett

6. DATE OF BIRTH (MONTH, DAY AND YEAR): June, 15, 1886

7. AGE

YEARS	MONTHS	DAYS	If LESS than 1 day, hrs. or min.
41	6.	5	

8. OCCUPATION OF DECEASED

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

(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): Perrin, Mo.

PARENTS

10. NAME OF FATHER: J.T. Wingate

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

12. MAIDEN NAME OF MOTHER: Lovella Brown

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

14. INFORMANT: William T. Hackett
(Address) Lawson, Mo.

15. FILED DEC 21 1927 19 John G. Utz REGISTRAR

MEDICAL CERTIFICATE OF DEATH

4

16. DATE OF DEATH (MONTH, DAY AND YEAR): Dec, 20, 1927 19

17. I HEREBY CERTIFY, That I attended deceased from Dec 20, 1927, to Dec. 20, 1927 that I last saw her alive on Dec. 20, 1927 and that death occurred, on the date stated above, at 7.45 P.M. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
General Peritonitis
Left Gangrenous Ruptured Ovarian Cyst.
1398
1398
129 (duration) yrs. mos. 4 ds.

CONTRIBUTORY (SECONDARY): Ovarian Cyst
(duration) yrs. several mos. ds.

18. WHERE WAS DISEASE CONTRACTED IF NOT AT PLACE OF DEATH? Kinnville, Mo.

DID AN OPERATION PRECEDE DEATH? yes. DATE OF Dec. 20-1927

WAS THERE AN AUTOPSY? Abdominal autopsy

WHAT TEST CONFIRMED DIAGNOSIS? Autopsy.

(Signed) Caryl Potter, M.D.

Dec. 20, 1927 (Address) 731 Faraon - St. Joseph, 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.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL: Plattsburg, Missouri — DATE OF BURIAL: Dec. 21 1927

20. UNDERTAKER: W. Meirshoffer, — ADDRESS: 1302 Faraon

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

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

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

1. PLACE OF DEATH
County: Buchanan — Registration District No.: 85 — File No.:
Township: — Primary Registration District No.: 1001 — Registered No.: 1311
City: St. Joseph (No. ..... St. ..... Ward)

2. FULL NAME: Ada Hackett

(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: F
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word): 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 1-26, 1928 John G. Ellis REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Dec 20 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:
General Peritonitis Cept.
Gangrenous ruptured Ovarian Cyst — Simple Ovarian Cyst
(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (SECONDARY) Ovarian Cyst — Simple
Not Malignant
(duration) ..... yrs. ..... mos. ..... ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH? 1307
DID AN OPERATION PRECEDE DEATH? ..... DATE OF
WAS THERE AN AUTOPSY?
WHAT TEST CONFIRMED DIAGNOSIS?
(Signed) Carl Potter, 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

S-36068