NOV 25 1930

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

Do not use this space.

33353

1. PLACE OF DEATH
County: Jefferson
Township: Central
City: Hillsboro (No. ..... St. ..... Ward)

Registration District No. 452
Primary Registration District No. 5577

File No.
Registered No.

2. FULL NAME: Fannie Rosena Haeken

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

Length of residence in city or town where death occurred 6 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: Richard G. Haeken

6. DATE OF BIRTH (MONTH, DAY AND YEAR): April 25, 1860

7. AGE: Years 71 | Months 6 | Days 4 | 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): Glaize Creek
(STATE OR COUNTRY): Mo.

PARENTS
10. NAME OF FATHER: James P. Moss
11. BIRTHPLACE OF FATHER (CITY OR TOWN): Glaize Creek
(STATE OR COUNTRY): Mo.
12. MAIDEN NAME OF MOTHER: Ella J. Lewis
13. BIRTHPLACE OF MOTHER (CITY OR TOWN): Ky.
(STATE OR COUNTRY)

14. INFORMANT: Mrs. James Lovelace
(Address): Hillsboro Mo.

15. FILED Dec 29, 1930 Wm. Williams
REGISTRAR

2 MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR): Oct 29 1930

17. I HEREBY CERTIFY, That I attended deceased from Oct, 1925 to 10-29, 1930, that I last saw her alive on 10-27, 1930, and that death occurred, on the date stated above, at 5:10 a.m.

THE CAUSE OF DEATH WAS AS FOLLOWS:
Chronic Nephritis
131
92B
(duration) 5 yrs. mos. ds.

CONTRIBUTORY (SECONDARY): Endocarditis
(duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED: Home
IF NOT AT PLACE OF DEATH
DID AN OPERATION PRECEDE DEATH? No DATE OF
WAS THERE AN AUTOPSY? No
WHAT TEST CONFIRMED DIAGNOSIS? Laboratory
(Signed) Chas. E. Fuller M. D.
11-1, 1930 (Address) De Soto 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: Hillsboro Cemetery
DATE OF BURIAL: Oct. 31 1930

20. UNDERTAKER: Donnell B. Dietrich
ADDRESS: De Soto

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.

MISSOURI STATE BOARD OF HEALTH
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CERTIFICATE OF DEATH

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH
County Jefferson Registration District No. 422 File No.
Township Central Primary Registration District No. 5577 Registered No.
City (No. , St. Ward)

2. FULL NAME Fannie Rosena Hacker

(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 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) April 25 1860

7. AGE

YEARS	MONTHS	DAYS	If LESS than 1 day, hrs. or min.
70	6	4	

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 Oct 29 1930 Wm Evans
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Oct 29 1930

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:

(duration) yrs. mos. ds.

CONTRIBUTORY
(SECONDARY)
(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

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.

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

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