

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

Do not use this space.

40584

**PLACE OF DEATH**

County St. Louis  
Township Central  
City Maplewood (No. 3131, Eddger Ave.)

Registration District No. 786  
Primary Registration District No. 4469

File No. \_\_\_\_\_  
Registered No. 62  
St. \_\_\_\_\_ Ward \_\_\_\_\_

**2. FULL NAME** Margaret E. Hyatt

(a) Residence No. 3131 Eddger Ave. 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 Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Widowed

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Oct. 4, 1846

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, _____ hrs. or _____ min.
	84	2	3	

**8. OCCUPATION OF DECEASED**

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

9. BIRTHPLACE (CITY OR TOWN) St. Charles County  
(STATE OR COUNTRY) Missouri

10. NAME OF FATHER William T. Boghy

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

12. MAIDEN NAME OF MOTHER Francis R. Snoodly

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

14. INFORMANT Francis Cochrane  
(Address) 3146 Sutton Ave.

15. FILED 12/8 1930 Mercedes Schuster  
REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) Dec. 7 1930

17. I HEREBY CERTIFY, That I attended deceased from 1925 19. to Dec. 7 19. 30  
that I last saw her alive on Dec. 7 19. 30 and that death occurred, on the date stated above, at 1, 15 a. m.

**THE CAUSE OF DEATH\* WAS AS FOLLOWS:**

Acute Peritonitis  
911 A  
9-7  
\_\_\_\_\_ (duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. 2 ds.

CONTRIBUTORY (SECONDARY) Albuminuria  
\_\_\_\_\_ (duration) 5 yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

18. WHERE WAS DISEASE CONTRACTED \_\_\_\_\_  
IF NOT AT PLACE OF DEATH at home

DID AN OPERATION PRECEDE DEATH? No DATE OF \_\_\_\_\_

WAS THERE AN AUTOPSY? No

WHAT TEST CONFIRMED DIAGNOSIS? clinical symptoms  
(Signed) H. A. Gardner M. D.

Dec. 8, 1930 (Address) 17 East Lockwood Ave.

\*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 New Haven Missouri DATE OF BURIAL Dec. 9 1930

20. UNDERTAKER Fertig Und. ADDRESS New Haven Missouri

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.

1930 12 8

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