

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

Do not use this space.

**1. PLACE OF DEATH**

County Harrison  
Township \_\_\_\_\_  
City Eagleville (No. \_\_\_\_\_)

Registration District No. 337  
Primary Registration District No. 4200

File No. 29025  
Registered No. 6  
St. \_\_\_\_\_ Ward) \_\_\_\_\_

**2. FULL NAME**

Hydia Jane McConnick  
(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 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 Robt. McConnick

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Jan-11-1857

7. AGE YEARS MONTHS DAYS If LESS than 1 day, \_\_\_\_\_hra. or \_\_\_\_\_min.  
77 6 25

**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) (STATE OR COUNTRY) Indiana

10. NAME OF FATHER James Botter

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) Ind

12. MAIDEN NAME OF MOTHER Rebecca Madsen

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

14. INFORMANT A. G. Johnston  
(Address) Eagleville

15. FILED 8/6 1934 Lois Dumas REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) Aug-6 1934

17. I HEREBY CERTIFY, That I attended deceased from 7-29 1934, to 8-6 1934 that I last saw her alive on 8-5 1934, and that death occurred, on the date stated above, at 2 P.M.

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

Chronic Myocarditis  
1868  
1918  
(duration) 3 yrs. mos. ds.  
CONTRIBUTORY (SECONDARY) Fracture of left leg  
(duration) \_\_\_\_\_ yrs. mos. 9 ds.

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

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

20. WAS THERE AN AUTOPSY? No

WHAT TEST CONFIRMED DIAGNOSIS? none  
(Signed) Dr. [Signature], M. D.

Aug 6, 1934 (Address) Eagleville 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 Eagleville, Mo DATE OF BURIAL 8/7 1934

20. UNDERTAKER Street [Signature] ADDRESS Eagleville Mo

A. 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.

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2



*Harrison*

WASHINGTON

6

Dear Sir:

It is essential that death certificates be complete in every particular in order that proper classification may be made. You are therefore requested to make every effort to obtain the following information, indicated by check marks, lacking from the death certificate.

Name: *Lyle Jane McCannick*  
Who died at \_\_\_\_\_ on *Aug 6 - 1934*  
Residence: No. \_\_\_\_\_ St. \_\_\_\_\_  
(If nonresident, city or town)

Length of residence in city or town where death occurred: Years \_\_\_\_\_ Months \_\_\_\_\_ Days \_\_\_\_\_  
Sex *F* Color or race *W* Single, ~~married~~, widowed or divorced: \_\_\_\_\_

Date of birth \_\_\_\_\_ Age: Years *27* Months *6* Days *25*

Occupation: (a) Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. (b) Industry or business in which work was done, as silk mill, saw mill, bank, etc.

Date deceased last worked at this occupation: *Chronic Myocarditis - Fracture of left hip* Month \_\_\_\_\_ Year \_\_\_\_\_

Birthplace (State or country) \_\_\_\_\_

Birthplace of father (State or country) \_\_\_\_\_

Birthplace of mother (State or country) \_\_\_\_\_

Principal cause of death: *Chronic Myocarditis - as noted on Certificate of Death*

Other contributory causes of importance \_\_\_\_\_  
Name of operation \_\_\_\_\_ Date of \_\_\_\_\_

What test confirmed diagnosis? \_\_\_\_\_ Was there an autopsy? \_\_\_\_\_

If death was due to external causes (violence) fill in also the following:  
Accident, suicide, or homicide? \_\_\_\_\_ Date of injury *7-29-34*

Where did injury occur? *In kitchen of home Eagleville Mo*  
(Specify city or town, county and State)

Specify whether injury occurred in *home* industry, in home, or in public place.

Manner of injury *Fell*

Nature of injury *Fracture of left hip*

Was disease or injury in any way related to occupation of deceased? *No*

If so, specify \_\_\_\_\_

Name of physician *W. S. Thayer*

Address of physician *Eagleville Mo*

Signature of Registrar *Lain Burns* Date filed \_\_\_\_\_

This information is sought for statistical purposes only and in order that the official report may be complete and correct. Please reply promptly using the enclosed official envelope which requires no postage.

Reg. Dist. No. *337*

Very truly yours,

*[Signature]*

Primary Reg. Dist. No. *4200*

Special Agent.

5-29025