

NOV 26 1935

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

Do not use this space.

33666

1. PLACE OF DEATH

County Polk
Township Madison
City (No. City) _____

Registration District No. 702
Primary Registration District No. 4423-578

File No. _____
Registered No. _____
St. _____ Ward _____

2. FULL NAME

Amos S Hackett

(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 Male 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 Amanda Hackett6. DATE OF BIRTH (MONTH, DAY AND YEAR) Dec 30 1850

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
84 9 14 7

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Farmer(b) General nature of industry, business, or establishment in which employed (or employer) Farm(c) Name of employer #

9. BIRTHPLACE (CITY OR TOWN)

(STATE OR COUNTRY) Illinois10. NAME OF FATHER C A Hackett

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY) Ill.12. MAIDEN NAME OF MOTHER Hannah M Gidding13. BIRTHPLACE OF MOTHER (CITY OR TOWN) England
(STATE OR COUNTRY)

14.

INFORMANT A. S. Hackett
(Address) Fair Play Mo

15.

FILED 10-4-1935 L. L. Hunt
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

1935

16. DATE OF DEATH (MONTH, DAY AND YEAR) Oct 3 1935

17. I HEREBY CERTIFY, That I attended deceased from Sept 1 1935 to Oct 2 1935 that I last saw h. in alive on Oct 2 1935 and that death occurred, on the date stated above, at 2:50 p. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Chronic urinary cystitis and fistula following operation for urinary calculi-

(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? Yes DATE OF 1927WAS THERE AN AUTOPSY? NoWHAT TEST CONFIRMED DIAGNOSIS Clinical
(Signed) Chas H Brown, M. D., 19 _____ (Address) Fair Play 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

DATE OF BURIAL

Gum Springs CemOct 19 35

20. UNDERTAKER

ADDRESS

Crow and ParkerFair Play Mo

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.

