

SEP 12 1934

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

Do not use this space.

1. PLACE OF DEATH

County Dent
Township Watkins
City (No., St. Ward)

Registration District No. 266
Primary Registration District No. 5-378

28823
File No.
Registered No. 5-7
St. Ward

2. FULL NAME Ezra Hyatt

(a) Residence, No. St. Ward.
(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. (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 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 Francis Smith

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Jan 5 1865

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
69 7 22

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Farmer

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.

10. Date deceased last worked at this occupation (month and year) 11. Total time (years) spent in this occupation.

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) --- New York13. NAME James Hyatt State14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) New York

15. MAIDEN NAME

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

17. INFORMANT N. N. Smelser
(ADDRESS) St. Louis, Mo18. BURIAL, CREMATION, OR REMOVAL PLACE Roseberry Cemetery DATE Aug. 28 '3419. UNDERTAKER Carl R. Spencer
(ADDRESS) Salisbury, Mo20. FILED 8/28 1934 W. E. Kadd, M.D.
Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Aug. 27 193422. I HEREBY CERTIFY, That I attended deceased from Aug 22, 1934, to Aug 27, 1934.I last saw him alive on Aug 26, 1934. Death is saidto have occurred on the date stated above, at 8:00 A.M.

The principal cause of death and related causes of importance were as follows:

Date of onset

Angina
97%
94%
95%
Other contributory causes of importance:

Cardiac dilatation
Sensibility

Name of operation..... Date of.....

What test confirmed diagnosis?..... Was there an autopsy?.....

23. If death was due to external causes (violence), fill in also the following:

Accident, suicide, or homicide?..... Date of injury....., 19.....

Where did injury occur?..... (Specify city or town, county, and State)

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

Manner of injury.....

Nature of injury.....

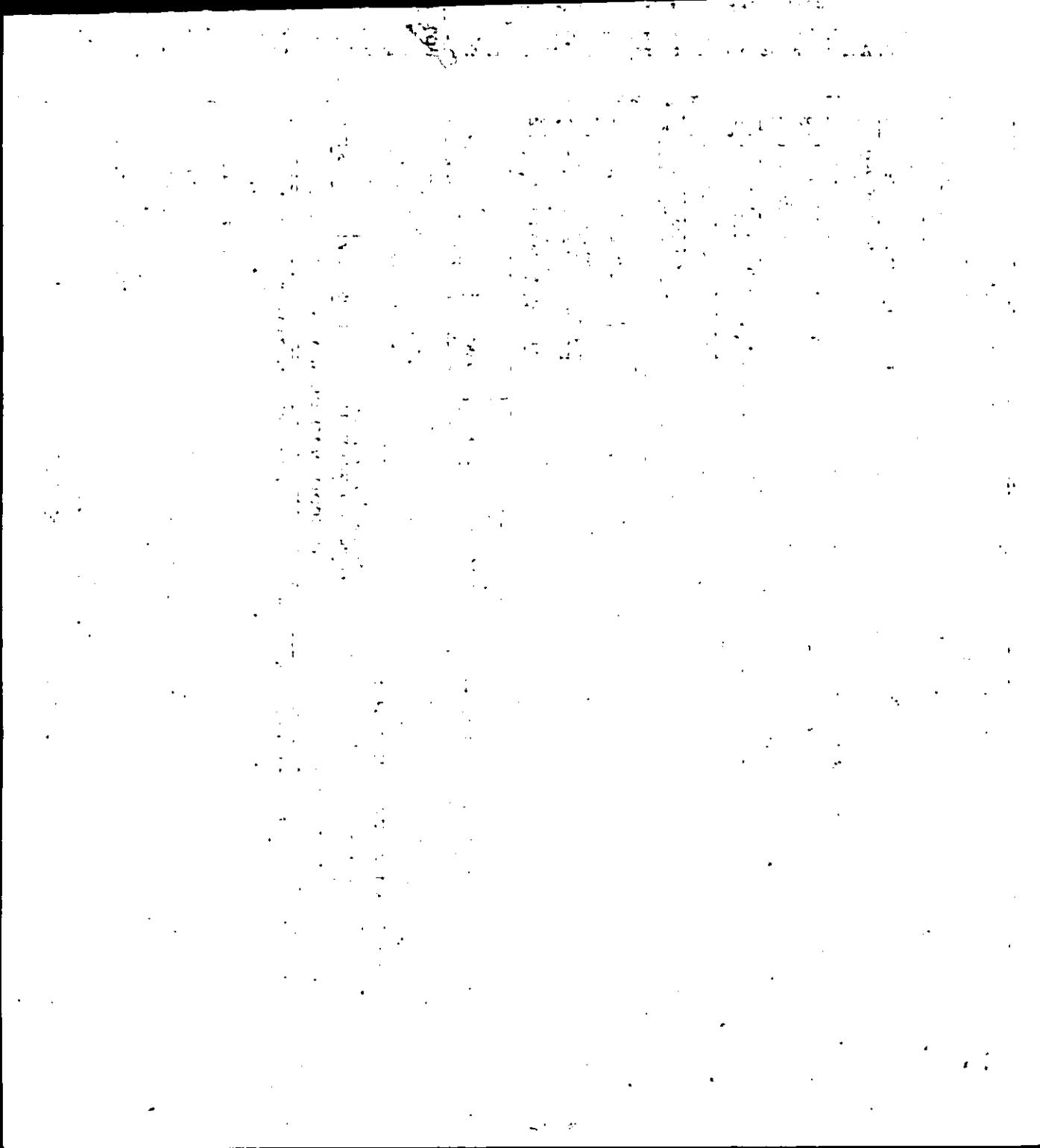
24. Was disease or injury in any way related to occupation of deceased?.....

If so, specify.....

(Signed) J. J. Irwin, M. D.(Address) Salisbury, 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.

WRITE PLAINLY, WITH CAPITAL LETTERS



WASHINGTON

Wash

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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: Ezra Hyatt
Who died at _____ on Aug 27 - 1931
Residence: No. _____ St. _____
(If nonresident, city or town)

Length of residence in city or town where death occurred: Years _____ Months _____ Days _____
Sex m Color or race w Single, married, widowed or divorced: _____

Date of birth: _____ Age: Years 69 Months 7 Days 22

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: Month _____ Year _____
Birthplace (State or country) _____
Birthplace of father (State or country) _____
Birthplace of mother (State or country) _____
Principal cause of death: Endocarditis, Chronic
Cardiac Angina

Other contributory causes of importance Pemility 92A
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 _____, 19 _____
Where did injury occur? _____
(Specify city or town, county and State)

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

Manner of injury _____
Nature of injury _____
Was disease or injury in any way related to occupation of deceased? _____
If so, specify _____
Name of physician J. O. Feick
Address of physician Salmon Mo.

Signature of Registrar W. E. Rudd 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. 266
Primary Reg. Dist. No. 5378

Very truly yours,
E. J. McLaughlin
g.c.
Special Agent.

5-28823

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