

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

PLACE OF DEATH

County: Adair

Township _____

Village _____

City: Kirkville (NO. 212 n. High)

Registration District No. 4

Primary Registration District No. 3001

File No. 36863

Registered No. 117

[If death occurred in a hospital or institution, give its NAME instead of street and number]

FULL NAME William A. Hamilton

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

SEX male COLOR OR RACE white SINGLE MARRIED WIDOWED OR DIVORCED married
(Write the word)

DATE OF DEATH Nov 16, 1911
(Month) (Day) (Year)

DATE OF BIRTH Nov 28th, 1851
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from May 19, 1911, to June 27, 1911, that I last saw him alive on June 27 at home, 1911, and that death occurred, on the date stated above, at 6 a. m. The CAUSE OF DEATH* was as follows:

AGE 60 yrs. 7 mos. 18 ds. If LESS than 1 day, ___ hrs. or ___ min.?

Tuberculosis of bowels
31
(Duration) 1 yrs. ___ mos. ___ ds.

OCCUPATION (a) Trade, profession, or particular kind of work Merchant
(b) General nature of industry, business, or establishment in which employed (or employer) mdse 4-33

Contributory Indigestion
(SECONDARY) (Duration) ___ yrs. 6 mos. ___ ds.

BIRTHPLACE (City or town, State or foreign country) Indiana

NAME OF FATHER W. A. Hamilton

(Signed) J. F. Dodson M. D.
11/19, 1911 (Address) Kirkville Mo

BIRTHPLACE OF FATHER (City or town, State or foreign country) about / know

MAIDEN NAME OF MOTHER Francis Singer

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

BIRTHPLACE OF MOTHER (City or town, State or foreign country) about / know

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ___ yrs. ___ mos. ___ ds. in the State ___ yrs. ___ mos. ___ ds.

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

Where was disease contracted if not at place of death? _____

(Informant) Mrs W. A. Hamilton

Former or usual residence _____

(ADDRESS) Kirkville

PLACE OF BURIAL OR REMOVAL Holland Park Cemetery DATE OF BURIAL Nov 18, 1911

Filed 11-19- 1911, E. S. Allison REGISTRAR

UNDERTAKER H. C. Wilson ADDRESS Kirkville

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.

Revised United States Standard Certificate of Death

[Approved by U. S. Census and American Public Health
Association]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Composer*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritonæum*, etc., *Carcinoma*, *Sar-*

coma, etc., of _____ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicaemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)



County Adair

Township _____

Registration District No. 4

File No. _____

Village _____

Primary Registration District No. 3001Registered No. 137City Kirksville (NO. _____)

St.: _____ Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number]

FULL NAME Wm A Hamilton

PERSONAL AND STATISTICAL PARTICULARS

SEX <u>M</u>	COLOR OR RACE <u>W</u>	SINGLE MARRIED WIDOWED OR DIVORCED (If write the word) <u>Married</u>
DATE OF BIRTH <u>3/28</u> , 18 <u>85</u> (Month) (Day) (Year)		
AGE <u>65</u> yrs. <u>7</u> mos. <u>18</u> ds.		If LESS than 1 day, ___ hrs. or ___ min. <u>2</u>

OCCUPATION
(a) Trade, profession, or particular kind of work grocery
(b) General nature of industry, business, or establishment in which employed (or employer) Member

BIRTHPLACE
(City or town, State or foreign country) Ind.

PARENTS	NAME OF FATHER <u>Wm A Hamilton</u>
	BIRTHPLACE OF FATHER (City or town, State or foreign country) <u>Ind.</u>
	MAIDEN NAME OF MOTHER <u>Margie Singer</u>
	BIRTHPLACE OF MOTHER (City or town, State or foreign country) <u>Ind.</u>

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs W A Hamilton
(ADDRESS) KirksvilleFiled 11-17 X 1911 X E. Ballison
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH 11/16, 1911
(Month) (Day) (Year)I HEREBY CERTIFY, that I attended deceased from 11/19, 1911, to 6/27, 1911, that I last saw him alive on 6/27, 1911, and that death occurred, on the date stated above, at 6 a m.

The CAUSE OF DEATH* was as follows:

tuberculosis of Bowels
(Duration) ___ yrs. ___ mos. ___ ds.Contributory suggestion
(SECONDARY)(Signed) J. F. Dodson M. D.
11/17, 1911 (Address) Kirksville

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ___ yrs. ___ mos. ___ ds. In the State ___ yrs. ___ mos. ___ ds.

Where was disease contracted if not at place of death?

Former or usual residence _____

PLACE OF BURIAL OR REMOVAL Nighland ParkDATE OF BURIAL 11-18, 1911UNDERTAKER J. F. DodsonADDRESS KirksvilleOriginal file, date NOV 1911

All information called for must be written on this Supplementary Certificate.

Revised United States Standard Certificate of Death

[Approved by U. S. Census and American Public Health Association]

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coma, etc., of _____ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicaemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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