

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

Do not use this space
6598

1. PLACE OF DEATH

County.....
Township.....
City *St. Louis* (No. *City Hospital #2*)

Registration District No. **791**
1003
County Registration District No.

File No.
Registered No. **1542**
St. Ward)

2. FULL NAME

Thomas Hamlett Hamlett
(a) Residence. No. *2133^d Adams St.* St. *22* Ward.
(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred *9* yrs. mos. da. How long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *Male* **4. COLOR OR RACE** *Col.* **5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)** *married*

5A. IF MARRIED, WIDOWER, OR DIVORCED HUSBAND OF (OR) WIFE OF *Annie Hamlett*

6. DATE OF BIRTH (MONTH, DAY AND YEAR) *Feb 19 1895*

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, hrs. or min.
	<i>32</i>	<i>11</i>	<i>19</i>	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work *Labourer*
(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) *Tenn.*

10. NAME OF FATHER *Alf. Hamlett*

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

12. MAIDEN NAME OF MOTHER *Finnetta Hunter*

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

14. INFORMANT (Address) *Anna F. Woodard City Hospital #2*

15. FILED *Feb 19 1928* *Maye Starling* REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) *Feb. 8 1928*

17. I HEREBY CERTIFY That I attended deceased from *Jan. 14 1928*, to *Feb. 8 1928*, that I last saw him alive on *Feb. 8 1928*, and that death occurred, on the date stated above, at *1214 Oa. m.*

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Acute Neuramnielitis
237

Miss G (duration) yrs. mos. *21* ds.

CONTRIBUTORY (SECONDARY) (duration) yrs. mos. da.

18. WHERE WAS DISEASE CONTRACTED *not known*
IF NOT AT PLACE OF DEATH.....

" DID AN OPERATION PRECEDE DEATH? (DATE OF *no*

WAS THERE AN AUTOPSY? *no*

WHAT TEST CONFIRMED DIAGNOSIS *clinical*
(Signed) *H. H. Howell* M. D.
, 19 (Address) *City Hosp. #2*

*State the DISEASE CAUSING DEATH, or if 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 *Columbia Tenn* **DATE OF BURIAL** *Feb 10 1928*

20. UNDERTAKER *J. E. Thomas* **ADDRESS** *3111 Lacey*

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.

MISSOURI STATE BOARD OF HEALTH

W. J. ...
S. B. ...

...

...

...