Larrell

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

Do not use this space.

32645

1. PLACE OF DEATH County Andrew Township Platte City Cameron (No. ..... St. ..... Ward)

Registration District No. 15 Primary Registration District No. 3019

File No. ..... Registered No. 9

2. FULL NAME Cora A. Hamaker

(a) Residence. No. Cameron St. ..... St., ... Ward.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

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.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F.

4. COLOR OR RACE W.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Widowed

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF James Hamaker

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Nov. 27. 1928

7. AGE Years 72 Months 11. Days 7. If LESS than 1 day, ... hrs. or ..... min.

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) Ohio

PARENTS

10. NAME OF FATHER Orlando Hunt.

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

12. MAIDEN NAME OF MOTHER Lettie Pogelewell

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

14. INFORMANT Allie Bletal
(Address) Ella Mo.

15. Filed Oct. 8, 1928 E. J. Harris Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Oct. 3 1928

17. I HEREBY CERTIFY, That I attended deceased from Sept. 26, 1927 to Oct. 3, 1928 that I last saw h. alive on Oct. 2, 1928, and that death occurred, on the date stated above, at 9:33 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Cardiophalitis
7 days
TB (duration) 2 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? — DATE OF —

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS? .....

(Signed) James R. Lamb M.D.
, 19 (Address) Barnard 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 Stanberry Mo. DATE OF BURIAL Oct. 5 1928

20. UNDERTAKER R. S. Taggart ADDRESS King City

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

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH
County: Andrew — Registration District No.: 13 — File No.:
Township: Platte — Primary Registration District No.: 3-019 — Registered No.: 9
City: (No. St. Ward)

2. FULL NAME: Cora A. Hamaker

(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: F
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word): Wid

5A. IF MARRIED, WIDOWED, OR DIVORCED
HUSBAND OF
(OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR) ~~Oct 27~~ Oct 27 1856

7. AGE: Years 72 — Months 11 — Days 6 — If LESS than 1 day, hrs. or min.

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

PARENTS
10. NAME OF FATHER
11. BIRTHPLACE OF FATHER (CITY OR TOWN)
(STATE OR COUNTRY)
12. MAIDEN NAME OF MOTHER
13. BIRTHPLACE OF MOTHER (CITY OR TOWN)
(STATE OR COUNTRY)

14. INFORMANT
(Address)

15. FILED Oct 8, 1928 E. C. Jefferson REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Oct 3 1928

17. I HEREBY CERTIFY, That I attended deceased from 19, to 19, that I last saw h alive on 19, and that death occurred, on the date stated above, at m.
THE CAUSE OF DEATH* WAS AS FOLLOWS:

(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? DATE OF
WAS THERE AN AUTOPSY?
WHAT TEST CONFIRMED DIAGNOSIS?
(Signed), M. D
, 19 (Address)

*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 19

20. UNDERTAKER — ADDRESS

SUPPLEMENTARY

N. B.— CAUSF ... tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state ... in terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.
REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

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