

28 1929

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

Do not use this space.

15279

1. PLACE OF DEATH

County Linn Registration District No. 500 File No. _____
Township Jefferson Primary Registration District No. 4303 Registered No. 11
City _____ (No. _____) St. _____ Ward _____

2. FULL NAME James Thomas Hamilton

(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. da. 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 Clara H. Schreck

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 1-24-1848

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
81 2 9

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Retired lumberman
(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) Belmont Co. Ohio

10. NAME OF FATHER John J. Hamilton

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

12. MAIDEN NAME OF MOTHER Margaret Graham

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

14. INFORMANT L.E. Hamilton (Address) Laclede Mo.

15. FILED 4/4, 1929 J.N. Jush REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Apr 3 1929

17. I HEREBY CERTIFY That I attended deceased from Jan 22 1924, to Apr 3 1929, that I last saw him alive on Apr 29, 1929, and that death occurred, on the date stated above, at _____ m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Chronic Interstitial Nephritis
191
many years (duration) yrs. mos. da.

CONTRIBUTORY (SECONDARY) ap. phary (duration) 6 yrs. mos. da.

18. WHERE WAS DISEASE CONTRIBUTED? (IF NOT AT PLACE OF DEATH) _____

DID AN OPERATION PRECEDE DEATH? no DATE OF _____

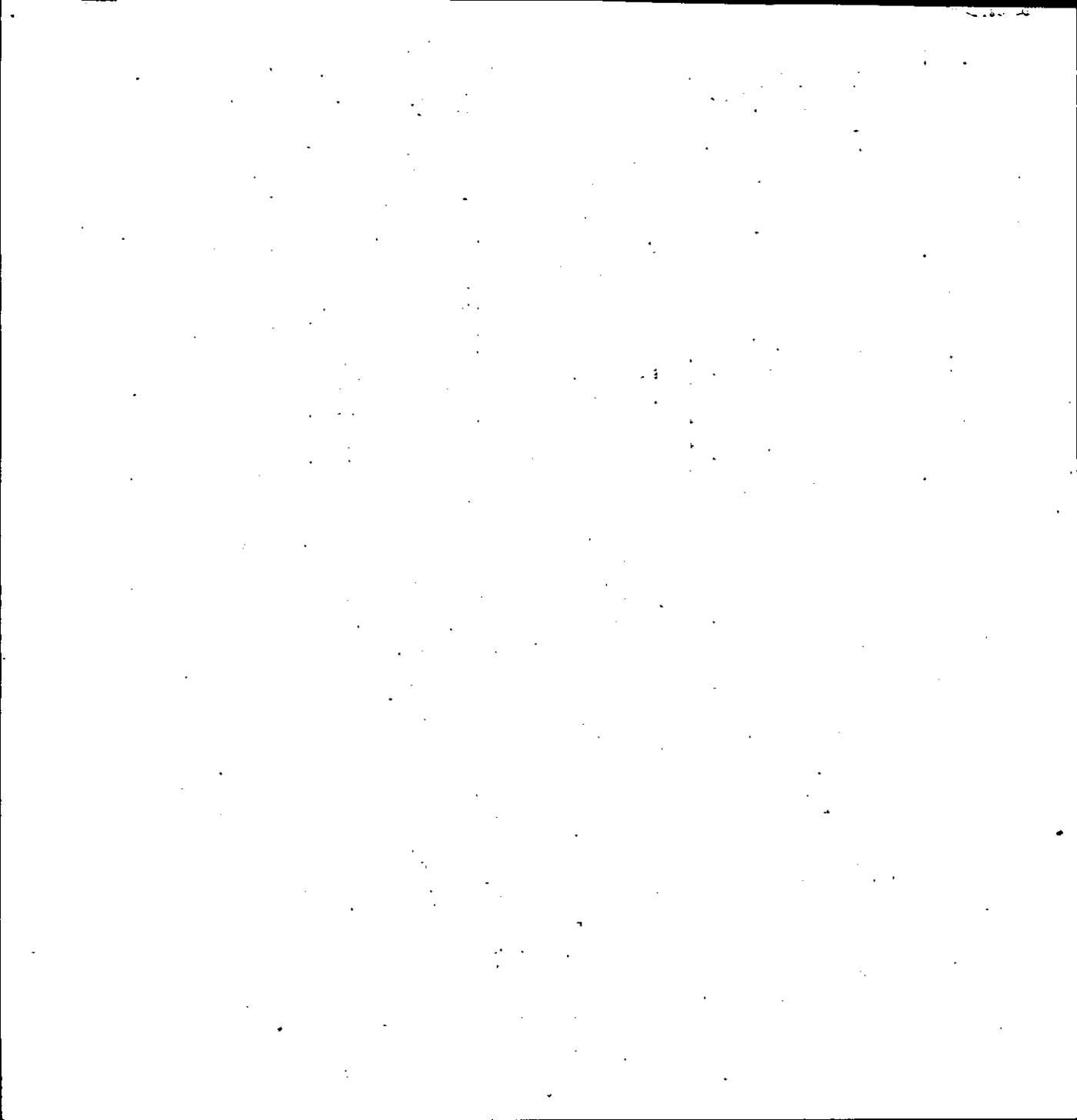
WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS? symptoms
(Signed) J.N. Jush, M. D.
4/4, 1929 (Address) Laclede 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 Laclede, Mo. DATE OF BURIAL Apr. 4 1929

20. UNDERTAKER J.G. Thorne ADDRESS Laclede, Mo.



**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 Jefferson Registration District No. 5-00 File No. _____
 Township Jefferson Primary Registration District No. 4-30-3 Registered No. 11
 City _____ (No. _____) St. _____ Ward _____

2. FULL NAME

James Thomas Hamilton
 (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 M 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) _____

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, _____ hrs. or _____ min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work _____ (duration) _____ yrs. _____ mos. _____ ds.
 (b) General nature of industry, business, or establishment in which employed (or employer) _____ (duration) _____ yrs. _____ mos. _____ ds.
 (c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN) _____ (STATE OR COUNTRY) _____

10. NAME OF FATHER _____

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

12. MAIDEN NAME OF MOTHER St. Anthony

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) St. Anthony (STATE OR COUNTRY) _____

14. INFORMANT _____ (Address) _____

15. FILED 14, 1929 J. J. Burke REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Apr 3 1929

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:

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 _____

20. UNDERTAKER _____ ADDRESS _____

REMARKS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

SUPPLEMENTARY

S-15279