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

Do not use this space.

File No. 17465

Registered No. 93

1. PLACE OF DEATH
County: Callaway,
Township: ~~Fulton,~~
City: Fulton, Mo, (No. ..... St. ..... Ward)

Registration District No. 104
Primary Registration District No. 5008

2. FULL NAME: Elizabeth Francis 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	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)
Female	White	Widowed

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR): July, 3rd, 1841

7. AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	87	9	29	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: House wife
(b) General nature of industry, business, or establishment in which employed (or employer): DO
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) .....
(STATE OR COUNTRY) Mo,

PARENTS
10. NAME OF FATHER: Joshaway Davis,
11. BIRTHPLACE OF FATHER (CITY OR TOWN) .....
(STATE OR COUNTRY) Mo,
12. MAIDEN NAME OF MOTHER: Sallie Graner,
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) .....
(STATE OR COUNTRY) Mo,

14. INFORMANT: Mrs, Vollie Craighead,
(Address) Fulton, Mo,

15. FILED May 2, 29 R. N. Crews
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR): May 2nd 1929

17. I HEREBY CERTIFY, That I attended deceased from May 1, 1929, to May 2, 1929 that I last saw her alive on May 1st 1929 and that death occurred, on the date stated above, at about 11, 30 A m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Chronic Nephritis
131

..... (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? No. DATE OF .....
WAS THERE AN AUTOPSY? No
WHAT TEST CONFIRMED DIAGNOSIS? Clinical
(Signed) H. L. Owen, M. D.
, 19 (Address) Fulton 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	DATE OF BURIAL
Liberty Christian Church	5-3-29 19
20. UNDERTAKER	**ADDRESS**
Herndon-Taylor Furn-Co	Fulton, Mo,

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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.