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

Do not use this space.

3899

FEB 20 1930

1. PLACE OF DEATH
County Worth — Registration District No. 116 V
Township Middlefork — Primary Registration District No. 6213
City Grant City (No. ..... St. ..... Ward) — File No. ..... Registered No. .....

2. FULL NAME Ada Mae 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 11 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)
F.	W	Married

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) April 30 1878

7. AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
51	8	28	

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) Page Co.
(STATE OR COUNTRY) Iowa

PARENTS

10. NAME OF FATHER John C. Svenberg
11. BIRTHPLACE OF FATHER (CITY OR TOWN) .....
(STATE OR COUNTRY) Sweden
12. MAIDEN NAME OF MOTHER Carrie Anderson
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) .....
(STATE OR COUNTRY) Sweden

14. INFORMANT John C. Svenberg
(Address) Red Oak Iowa

15. FILED Feb 4 1930 A. Chambers
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Jan 28 1930

17. I HEREBY CERTIFY, That I attended deceased from Dec ..., 1929, to Jan 30, 1930, that I last saw h... alive on Jan 27, 1930, and that death occurred, on the date stated above, at ... m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Mitral insufficiency
42A
..... (duration) 2 yrs. ... mos. ... ds.
CONTRIBUTORY (SECONDARY) 900
..... (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? Physical findings.
(Signed) J. Ross, M. D
, 19 (Address) Grant City 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
Grant City Cemetery	1/30 1930
20. UNDERTAKER Arch C. Dunfee	ADDRESS Grant City Mo.

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.

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