OCT 28 1930

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

Do not use this space.

29654

File No.

Registered No. 727

1. PLACE OF DEATH

County Greene — Registration District No. 368

Township — Primary Registration District No. 2001

City Springfield (No. 2248 Lyon St. Ward)

2. FULL NAME Denton Eugene Hamilton

(a) Residence. No. 2248 Lyon St., Ward. (If nonresident, give city or town and State)
(Usual place of abode)

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: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write* the word): Infant

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Sep 2 - 1930

7. AGE — YEARS — MONTHS — DAYS: 24 — If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Infant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

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

PARENTS

10. NAME OF FATHER E F Hamilton

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

12. MAIDEN NAME OF MOTHER Dortha E Cole

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

14. INFORMANT E F Hamilton (Address) 2248 Lyon

15. FILED 9 27, 1930 Lon Sharp REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Sept 26 1930

17. I HEREBY CERTIFY, That I attended deceased from Sept 2, 1930, to Sep 26, 1930 that I last saw him alive on Sept 26, 1930 and that death occurred, on the date stated above, at 3 30 P. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Idiopathic Hemorrhage

1610

(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) [signature], M. D.

9 27, 1930 (Address) Springfield

*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: Ruth Chappell Cem — DATE OF BURIAL: Sep 27 1930

20. UNDERTAKER: J A Klingner & Co — ADDRESS: Springfield 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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