

NOV 3 1930

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

Do not use this space.

31928

1. PLACE OF DEATH

County Vernon  
Township Washington  
City \_\_\_\_\_ (No. \_\_\_\_\_)

Registration District No. 875  
Primary Registration District No. 6162

File No. \_\_\_\_\_  
Registered No. 204  
St. \_\_\_\_\_ Ward)

2. FULL NAME

J. H. 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*) widowed

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) DK-1853

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.  
77 DK DK

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Farmer  
(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) Mo

10. NAME OF FATHER Geo Hamilton

11. BIRTHPLACE OF FATHER (CITY OR TOWN) \_\_\_\_\_ (STATE OR COUNTRY) Ill

12. MAIDEN NAME OF MOTHER Sarah Roberson

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) \_\_\_\_\_ (STATE OR COUNTRY) Ill

14. INFORMANT State Hospital Records (Address) Merada Mo

15. FILED 10/4/30 E. P. King REGISTRAR

2. MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Sept 29 1930

17. I HEREBY CERTIFY, That I attended deceased from May 15, 1929 to Sept 29, 1930 that I last saw him alive on Sept 29, 1930 and that death occurred, on the date stated above at 7:40 A M.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:

93  
Chronic Myocarditis  
97 (duration) 2 yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.  
CONTRIBUTORY Astria Sclerosis  
(SECONDARY) (duration) 2+ 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) E. H. Coon M. D.

9/29 1930 (Address) Merada 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

Dep. Mo.

9-30-30

20. UNDERTAKER

ADDRESS

Merstunel Home Merada

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.

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

