

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

Do not use this space.

30418

1. PLACE OF DEATH

County Adair

Registration District No. 4

Township _____

Primary Registration District No. 3001

City Kirkville (No. _____)

File No. _____

Registered No. 160

St. _____ Ward _____

2. FULL NAME

John A Hamilton

(a) Residence. No. 710 N. Elson 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

Male

4. COLOR OR RACE

White

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

Married

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

Sarah Hamilton

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

9-13-1852

7. AGE

YEARS 79

MONTHS 0

DAYS 8

If LESS than 1 day, _____ hrs. or _____ min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Ret'd 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) Pa.

10. NAME OF FATHER

James Hamilton

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY) Pa.

12. MAIDEN NAME OF MOTHER

Clara Powell

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY) Pa.

14.

INFORMANT Sarah Hamilton

(Address) 710 N. Elson, Kirkville

15.

FILED 9/25/1931 Mrs C. Becker REGISTRAR

2 MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 9-21-1931

17. I HEREBY CERTIFY, That I attended deceased from _____, 1931, to _____, 1931, that I last saw him alive on _____, 1931, and that death occurred, on the date stated above, at _____ m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

ly. protuber. of head
a. apoplexy
95B

CONTRIBUTORY (SECONDARY)

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH

8 DID AN OPERATION PRECEDE DEATH? _____ DATE OF _____

WAS THERE AN AUTOPSY?

WHAT TEST CONFIRMED DIAGNOSIS

(Signed) J. B. Fanning M. D.

. 19 (Address) Kirkville, 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

near Kirkville
Bear Creek

9-23-1931

20. UNDERTAKER

ADDRESS

Dee Riley

Kirkville

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.

OCT 22 1931

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