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

1. PLACE OF DEATH
County: Vernon — Registration District No. 876 — File No. 4510
Township: Richland — Primary Registration District No. 6163 — Registered No.
City: ~~Richards~~ (No. ..... St. ..... Ward)

2. FULL NAME: Logan Russell Hamlett
(a) Residence. No. ..... St., ..... Ward. ..... (If nonresident give city or town and State)
(Usual place of abode)
Length of residence in city or town where death occurred 1 yrs. 1 mos. 15 ds. How long in U.S., if of foreign birth? yrs. mos. ds.

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX: Male
4. COLOR OR RACE: Wht
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word): Infant
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF: Infant
6. DATE OF BIRTH (MONTH, DAY AND YEAR): Dec 14-1931
7. AGE: Years 1 — Months 1 — Days 15 — 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) (STATE OR COUNTRY): Richards Mo.

PARENTS
10. NAME OF FATHER: L W Hamlett
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY): None Cedar Co Mo.
12. MAIDEN NAME OF MOTHER: Emma Gull
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY): Big Lake Mo.

14. INFORMANT: L V Hamlett
(Address): Richards Mo
15. FILED: Jan 31 1933 — Nettie Richards, REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

2

16. DATE OF DEATH (MONTH, DAY AND YEAR): Jan 29 1933
17. I HEREBY CERTIFY, That I attended deceased from ~~Jan 26~~ Jan. 26, 1933, to Jan. 29, 1933 that I last saw ~~him~~ ~~alive~~ dead on Jan. 29, 1933, and that death occurred, on the date stated above, at 11:15 a.m., m.
THE CAUSE OF DEATH* WAS AS FOLLOWS:
9 Bronchial Pneumonia
10 Mo
..... (duration) ..... yrs. ..... mos. 2 ds.
CONTRIBUTORY (SECONDARY): Whooping Cough
..... (duration) ..... yrs. ..... mos. 15 ds.
18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH? ✓
DID AN OPERATION PRECEDE DEATH? ✓ DATE OF
WAS THERE AN AUTOPSY? ✓
WHAT TEST CONFIRMED DIAGNOSIS? ✓
(Signed) R. O. Gunner, M. D
1-30, 1933 (Address) Ft Scott Ks

*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. (See reverse side for additional space.)

19. PLACE OF BURIAL, CREMATION, OR REMOVAL: Wall Cemetery — DATE OF BURIAL: Jan 30 1933
20. UNDERTAKER: O W Cheney — ADDRESS: 14 Scott Kan

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

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

**1. PLACE OF DEATH**

County..... Registration District No..... File No.....

Township..... Primary Registration District No..... Registered No. .....

City..... (No....., .....St. .....Ward)

**2. FULL NAME** .....

(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) |
|---|---|---|
| | | |

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

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

| 7. AGE | YEARS | MONTHS | DAYS | If LESS than 1 day, .....hrs. or .....min. |
|---|---|---|---|---|
| | | | | |

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work .....

(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)

PARENTS

10. NAME OF FATHER

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

12. MAIDEN NAME OF MOTHER

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

14.
INFORMANT .....
(Address)

15.
FILED....., 19..... .....
REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 19

17.
I HEREBY CERTIFY, That I attended deceased from .....
....., 19....., to ....., 19.....
that I last saw h..... alive on....., 19....., and that death occurred, on the date stated above, at.....m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

.....
.....
.....
.....(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?..... DATE OF.....

WAS THERE AN AUTOPSY?.....

WHAT TEST CONFIRMED DIAGNOSIS?.....

(Signed)....., M. D
, 19 (Address)

*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. (See reverse side for additional space.)

| 19. PLACE OF BURIAL, CREMATION, OR REMOVAL | DATE OF BURIAL 19 |
|---|---|
| 20. UNDERTAKER | ADDRESS |

N. B.—Every item of information should be entered, especially CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.