

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

Do not use this space.

30590

1. PLACE OF DEATH

County Pulaski
Township Cullum
City (No. St. Ward)

Registration District No. 763
Primary Registration District No. 5942

File No.
Registered No.

2. FULL NAME

(a) Residence, No. St. Ward
(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. (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

1 MEDICAL CERTIFICATE OF DEATH

3. SEX male 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) single

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Sept 6, 1933

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

22. I HEREBY CERTIFY, That I attended deceased from Aug 31, 1933 to Sept 6, 1933

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Sept 6, 1933

I last saw him alive on Sept 6, 1933 Death is said to have occurred on the date stated above, at 2:20 p.m.

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. min. 1 3 11

The principal cause of death and related causes of importance were as follows:

Illio-Colitis Date of onset 8-27-33

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. none

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. none

10. Date deceased last worked at this occupation (month and year) 11. Total time (years) spent in this occupation

119B
119B
Other contributory causes of importance

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Waynesville Mo

13. NAME W. H. Hamilton

Name of operation crane Date of

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Paris Ill

What test confirmed diagnosis? none Was there an autopsy? no

15. MAIDEN NAME Ruth Miller

23. If death was due to external causes (violence), fill in also the following: Accident, suicide, or homicide? no Date of injury , 19

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Ill

Where did injury occur? (Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place.

17. INFORMANT W. H. Hamilton (ADDRESS) Waynesville Mo

Manner of injury

18. BURIAL, CREMATION, OR REMOVAL PLACE Palestine Ill DATE 9/7/33

Nature of injury

19. UNDERTAKER J. Heppner Sons (ADDRESS) Empire Mo

24. Was disease or injury in any way related to occupation of deceased? no
If so, specify

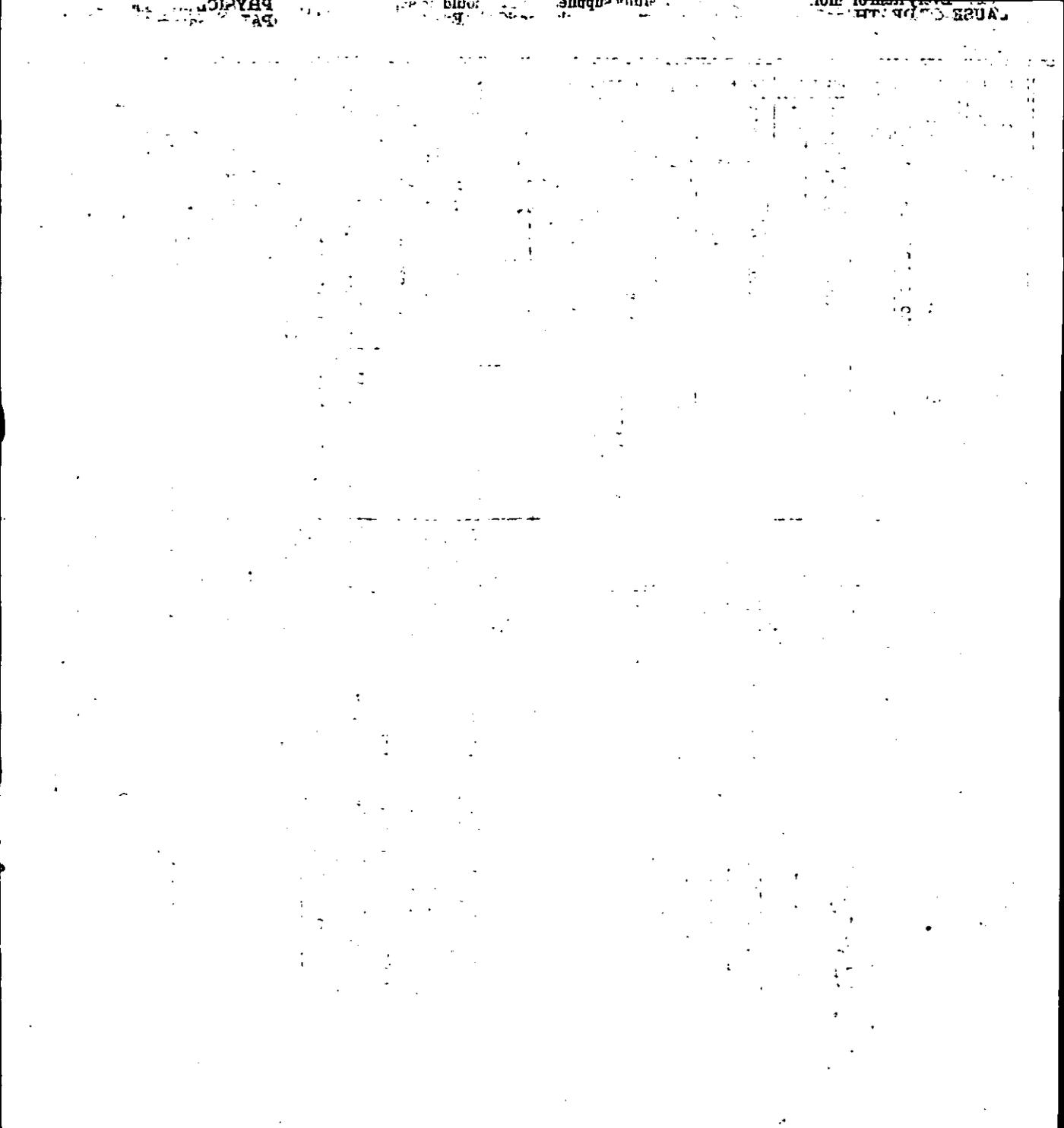
20. FILED 9/6, 1933 Chalot Registrar.

(Signed) E. Walford M. D.
(Address) Brocker, Mo

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

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

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH

County DeKalb
Township Cullen
City (No. _____) _____ St. _____ Ward _____

Registration District No. 713
Primary Registration District No. 5942

File No. 30590
Registered No. _____

2. FULL NAME

W. 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) s

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) May 26th 1932

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
1 3 10

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc.
9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.
10. Date deceased last worked at this occupation (month and year) _____
11. Total time (years) spent in this occupation _____

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) _____

13. NAME _____

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) _____

15. MAIDEN NAME _____

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) _____

17. INFORMANT (ADDRESS) _____

18. BURIAL, CREMATION, OR REMOVAL PLACE _____ DATE _____ 19 _____

19. UNDERTAKER (ADDRESS) _____

20. FILED _____ 19 _____ W. H. Hamilton Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Sept 6, 1933

22. I HEREBY CERTIFY, That I attended deceased from _____ to _____, 19____
I last saw h. _____ alive on _____, 19____. Death is said to have occurred on the date stated above, at _____ m.

The principal cause of death and related causes of importance were as follows:

Date of onset _____
Other contributory causes of importance: _____

Name of operation _____ Date of _____
What test confirmed diagnosis? _____ Was there an autopsy? _____

23. If death was due to external causes (violence), fill in also the following: Accident, suicide, or homicide? _____ Date of injury _____, 19____
Where did injury occur? _____ (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place. _____

Manner of injury _____
Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased? _____
If so, specify _____

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

SUPPLEMENTARY

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.
CAUSE OF DEATH IN plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. AGE should be stated EXACTLY. PHYSICIANS should state every detail of information known or caremity supplied.

S-30590