

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.

MAR 24 1934

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

Do not use this space.

1. PLACE OF DEATH

County *Adair*  
Township *Winnemah*  
City *Winnemah* (No. *1*)

Registration District No. *2*  
Primary Registration District No. *5002*

File No. *3776*  
Registered No. *3*  
St. \_\_\_\_\_ Ward \_\_\_\_\_

2. FULL NAME

*William Garfield 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 <i>Male</i>	4. COLOR OR RACE <i>White</i>	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) <i>Married</i>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF <i>Taura Hamilton</i>		
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) <i>July 5, 1882</i>		
7. AGE YEARS <i>51</i>	MONTHS <i>7</i>	DAYS <i>7</i>
8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. <i>Farmer</i>		
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) <i>MO</i>		
13. NAME <i>Robert Hamilton</i>		
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <i>Indiana</i>		
15. MAIDEN NAME <i>Shirilda Jackson</i>		
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <i>MO</i>		
17. INFORMANT (ADDRESS) <i>Laura Hamilton Harrison, Mo.</i>		
18. BURIAL, CREMATION, OR REMOVAL PLACE <i>Salseno Point</i> DATE <i>Feb. 14</i> 19 <i>34</i>		
19. UNDERTAKER (ADDRESS) <i>Hew Ellyn &amp; Son Harrison, Mo.</i>		
20. FILED <i>7/19</i> 19 <i>34</i> <i>J. S. Garbner</i> Registrar		

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) *Feb 12* 19*34*

22. I HEREBY CERTIFY, That I attended deceased from *face* *Jan 15* 19*33* to *Feb 12* 19*34*  
I last saw him alive on *Jan 15* 19*34* Death is said to have occurred on the date stated above, at *6:30 P.M.*  
The principal cause of death and related causes of importance were as follows:  
*Valvular Heart Disease - Chronic* 19*33*

Other contributory causes of importance:  
*92A*

Name of operation *none* 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) *A. J. Harrison* M.  
(Address) *Harrison, Mo.*

