

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

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.

DESD APR 19 1939

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

11300
Do not use this space.

1. PLACE OF DEATH

(a) County Laclede Registration District No. 449
 (b) Township 1 Primary Registration District No. 1267 Registered No. _____
 (c) City Keokuk (d) Street No. _____ St. _____
 (If death occurred in Hospital or Institution, write its name instead of street and number)
 (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME

543 Jess Waldo Hamilton
 (a) Residence, No. Competition MO St. (If nonresident, give city or town and State)
 (Usual place of abode, if no street address, write county of city)

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 Rosa May Hamilton
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) January 18, 1885
 7. AGE YEARS 54 MONTHS 2 DAYS _____ If LESS than 1 day, _____ hrs. or _____ min.

OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Farmer
 9. Industry or business in which work was done, as 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) Wright Co. Mo.

FATHER 13. NAME C. V. Hamilton
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Wright Co. Mo.

MOTHER 15. MAIDEN NAME Hila Clayton
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Wright Co. Mo.

17. INFORMANT (ADDRESS) Mrs. Ruth Van Stavern

18. BURIAL, CREMATION, OR REMOVAL PLACE McBride DATE Mar. 19, 1939

19. FUNERAL DIRECTOR (ADDRESS) W. B. Holman Lebanon Mo.

20. FILED 3-18-39 J. A. McComb Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) March 17, 1939
 22. I HEREBY CERTIFY, That I attended deceased from 3-17, 1939 to 3-17, 1939.
 I last saw him alive on 3-17, 1939 Death is said to have occurred on the date stated above, at 11:30 P. M.
 The principal cause of death and related causes of importance were as follows:

Acute Myocardial Failure with Collapse. Date of onset 3/17/39.
 Other contributory causes of importance: 122.4
Nephritis
Mental Depression & Anemia.

Name of operation _____ Date of _____
 What test confirmed diagnosis? none Was there an autopsy? no

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? no
 If so, specify _____
 (Signed) Paul A. Jenkins, M. D.
 (Address) Lebanon, Missouri

RECEIVED
District Health Officer No. 7
District File Number: 7-39-517
Date Filed: 4-12-39

STATEMENT BY LICENSED EMBALMER

I, Carl W. Harse Licensed Embalmer No. 3955

hereby certify that the body recorded on the reverse side of this certificate was embalmed by Myself

L. E. _____

No. _____ or by _____ Registered Apprentice No. _____

working under my personal supervision.

Signed Carl W. Harse

Licensed Embalmer No. 3955

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)