

REC'D APR 24 1939

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

11422
Do not use this space.

1. PLACE OF DEATH
- (a) County Linn Registration District No. 496
- (b) Township Brookfield Primary Registration District No. 3025 Registered No. 29
- (c) City Brookfield (d) Street No. _____ St.
- (e) Length of residence in city or town where death occurred 35 yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.
2. PRINT FULL NAME Ernest James Hamilton
- (a) Residence, No. 432 market St. (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX <u>m</u>	4. COLOR OR RACE <u>w</u>	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) <u>married</u>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF <u>Gertrude Cora Hamilton</u>		
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) <u>Dec. 8-1889</u>		
7. AGE <u>49</u>	YEARS <u>3</u>	MONTHS <u>15</u>
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. <u>farmer</u>		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) <u>Chariton County Mo.</u>		
13. NAME <u>James A. Hamilton</u>		
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>unknown</u>		
15. MAIDEN NAME <u>Carrie Wells</u>		
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>unknown</u>		
17. INFORMANT <u>Mrs. Gertrude Hamilton</u> (ADDRESS) <u>Brookfield Mo.</u>		
18. BURIAL, CREMATION, OR REMOVAL PLACE <u>Rose Hill - Brookfield</u> DATE <u>Mar 26 1939</u>		
19. FUNERAL DIRECTOR (NAME) (ADDRESS) <u>Bill Purser Chokel Brookfield Mo</u>		
20. FILED <u>April 1 1939</u> <u>Brookfield</u> Local Registrar.		

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) March 23 1939

22. I HEREBY CERTIFY, That I attended deceased from 3/16 1939 to 3/23 1939
I last saw him alive on 3/23 1939. Death is said to have occurred on the date stated above, at 5:00 P. m.
The principal cause of death and related causes of importance were as follows:

Date of onset 10da

Other contributory causes of importance: Injury to auto 4da

Name of operation _____ Date of _____
What test confirmed diagnosis? all the 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? 6 (Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place.

Manner of injury 0
Nature of injury 6

24. Was disease or injury in any way related to occupation of deceased? No
If so, specify _____ (Signed) James W. Long, M. D.
445 (Address) Brookfield, Mo.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

932

RECEIVED

District Health Officer No. 10

District File Number 10-39-591

Date Filed APR 13 1939

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,

J. W. Blacklock

or by

Registered Apprentice No., working under my personal supervision.

Signed.....

J. W. Blacklock

Licensed Embalmer No. 2249

P. O. Address Brookfield Mo.

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.)

If this body is not embalmed, above space should be left blank.

FILL IN ANSWERS TO ALL SPACES
CHECKED IN RED PENCIL.

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PLACE OF DEATH

(a) County Linn Registration District No. 496
(b) Township _____ Primary Registration District No. 3025-
(c) City Brookfield (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

Ernest James Hamilton
(a) Residence, No. _____ St. (If nonresident, give city or town and State)
(Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX m 4. COLOR OR RACE w 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED W (write the word)

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 3 - 23 - 1938

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

22. I HEREBY CERTIFY, That I attended deceased from _____, 19____ to _____, 19____

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

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:

7. AGE YEARS 49 MONTHS 3 DAYS 15- If LESS than 1 day,hrs. ormin.

Pneumonia (Date of onset) 10/14

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.
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.....

(Bronchial)
Other contributory causes of importance; Myo Carditis (acute)

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. FUNERAL DIRECTOR (ADDRESS)

20. FILED 19____ Local Registrar.

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) Jno. McFarney, M. D.
(Address) Brookfield, Mo.

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

SUPPLEMENTARY

