

NOV 14 1939

State File No. _____

Registration District No. _____

Primary Registration District No. 656-59

Registrar's No. _____

1. PLACE OF DEATH 2

(a) County Plumstead
 (b) City or town Caster
 (c) Name of hospital or institution: _____
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution _____ (Specify whether)
 In this community at home years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Plumstead
 (c) City or town Caster
 (If outside city or town limits, write "RURAL")
 (d) Street No. _____ (If rural, give location)
 (e) If foreign born, how long in U. S. A. _____ years.

3. (a) PRINT FULL NAME Margaret Hamilton

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex Female 5. Color or race White 5. (a) Single, widowed, married, divorced Widow

6. (b) Name of husband or wife J. B. Hamilton 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased Dec 26 - 1879
 (Month) (Day) (Year)

8. AGE: Years 59 Months 9 Days 26 If less than one day _____ hr. _____ min.

9. Birthplace _____ (City, town, or county) _____ (State or foreign country)

10. Usual occupation _____

11. Industry or business _____

12. Name John Elliott

13. Birthplace _____ (City, town, or county) _____ (State or foreign country)

14. Maiden name H. H.

15. Birthplace Mo. R. (City, town, or county) _____ (State or foreign country)

16. (a) Informant's own signature John Gaidon Hamilton

(b) Address Remond Mo

17. (a) _____ (b) Date thereof 10-23-39
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Lexington Home

18. (a) Signature of funeral director Hand in name

(b) Address Bluffsville Mo

19. (a) 10-22 (b) John Gaidon
 (Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct day 22
 year 1939 hour 4 minute 40 M.

21. I hereby certify that I attended the deceased from Aug 24, 1939, to Oct 21, 1939;
 that I last saw h _____ alive on _____, 19____;
 and that death occurred on the date and hour stated above.

Immediate cause of death Pylonephritis

Due to _____
 Due to _____
 Other conditions (Include pregnancy within 3 months of death) _____

Major findings: _____
 Of operations _____
 Of autopsy _____

22. If death was due to external causes, fill in the following:
 (a) Accident, suicide, or homicide (specify) _____
 (b) Date of occurrence _____
 (c) Where did injury occur? _____ (City or town) _____ (County) _____ (State)
 (d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work? _____ (Specify type of place) _____ (e) Means of injury _____

23. Signature P. E. Craper (M. D. or other) _____
 Address Caster Mo. Date signed 10-22-39

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE 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.

RECEIVED FIELD STATE OFFICE
INDEX CARD RETURNED TO DISTRICT
DATE 10-1-37

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, or by.....
....., Registered Apprentice No.....
working under my personal supervision.

Signed.....

Licensed Embalmer No.....

P. O. Address.....

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.

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

Do not use this space.

36828

1. PLACE OF DEATH

County Pemiscot
Township Coastre
City..... (No.....)

Registration District No. 6576
Primary Registration District No. 3873

File No.....
Registered No.....
St. Ward)

2. FULL NAME

Margrett 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 7 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED Wid
(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. ormin.
59 9 26

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) Tenn

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 1-10 1940 Pompage Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Oct 22 1939

22. I HEREBY CERTIFY, That I attended deceased from 19....., 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) R. E. Cooper, M. D.

(Address) Coastre

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 impor-

