

FILED FEB 15 1940

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 3410

Registration District No. 701

Primary Registration District No. 5930

Registrar's No. 1

1. PLACE OF DEATH: 2  
(a) County Polk  
(b) City or town Marion sup-Rural  
(c) Name of hospital or institution:  
(If outside city or town limits, write "RURAL" and name of township)  
(d) Length of stay: In hospital or institution \_\_\_\_\_  
(Specify whether \_\_\_\_\_)  
In this community \_\_\_\_\_  
years, months or days 5 11

2. USUAL RESIDENCE OF DECEASED:  
(a) State Mo (b) County Polk  
(c) City or town Marion Mo  
(If outside city or town limits, write "RURAL")  
(d) Street No. Marion  
(If rural, give location)  
(e) If foreign born, how long in U. S. A. \_\_\_\_\_ years.

3. (a) PRINT FULL NAME George W. Hamblton  
3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

MEDICAL CERTIFICATION  
20. DATE OF DEATH, Month Jan day 4  
year 1940 hour 1 minute 45 P. M.

4. Sex Male 5. Color or race white 6. (a) Single, widowed, married, divorced Married  
6. (b) Name of husband or wife Cora 6. (c) Age of husband or wife if alive 58 years  
7. Birth date of deceased April 5 1879  
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from Jan 27 1940, to Jan 4 1940, that I last saw him alive on Jan 4 1940, and that death occurred on the date and hour stated above.

8. AGE: Years 60 Months 9 Days 1 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

Immediate cause of death Circumstances of the prostate  
Due to \_\_\_\_\_  
Due to 51

9. Birthplace Polk Co. Mo.  
(City, town, or county) (State or foreign country)

Other conditions (include pregnancy within 3 months of death) \_\_\_\_\_  
Major findings: Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_

10. Usual occupation Farmer

11. Industry or business \_\_\_\_\_  
12. Name Elgie Hamblton  
18. Birthplace Mo.  
(City, town, or county) (State or foreign country)

MOTHER { 14. Maiden name Naomi Hamblton  
15. Birthplace Mo.  
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Cora Hamblton  
(b) Address Marion Mo.

17. (a) \_\_\_\_\_ (b) Date thereof \_\_\_\_\_  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation Hickory Grove

18. (a) Signature of funeral director W. H. ...  
(b) Address Polk Co. Mo.

19. (a) 1/19/40 (b) J. W. ...  
(Date received local registrar) (Registrar's signature)

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 E. J. ... (M. D. or other) \_\_\_\_\_  
Address Polk Co. Mo. Date signed 1-6-40

PHYSICIAN  
Underline the cause to which death should be charged statistically.

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  
District Health Officer No. 7,  
District File Number 2-40-183  
Date Filed 2-12-48

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 Sherald O Marshall

Licensed Embalmer No. 3579

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.