

APR 14 1940

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

6850
Do not use this space.

1. PLACE OF DEATH

(a) County IRON Registration District No. 390
(b) Township Union Primary Registration District No. 5545
(c) City _____ (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.

Registered No. 4

2. PRINT FULL NAME 543 JOHN HIRAM HAMILTON

(a) Residence, No. ANYAPOLIS Mo. 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

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 THENA MADEL HAMILTON
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) APRIL 21, 1893
7. AGE YEARS 46 MONTHS 10 DAYS 8 If LESS than 1 day, _____ hrs. or _____ min.
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. FARMING.
10. Date deceased last worked at this occupation (month and year) _____ 11. Total time (years) spent in this occupation _____

12. BIRTHPLACE (CITY OR TOWN) IRON COUNTY
(STATE OR COUNTRY) MISSOURI

13. NAME DREW D HAMILTON

14. BIRTHPLACE (CITY OR TOWN) IRON COUNTY
(STATE OR COUNTRY) MISSOURI

15. MAIDEN NAME SARAH JANE CARBON

16. BIRTHPLACE (CITY OR TOWN) IRON COUNTY
(STATE OR COUNTRY) MISSOURI

17. INFORMANT DAVID D HAMILTON
(ADDRESS) ANYAPOLIS MO.

18. BURIAL, CREMATION, OR REMOVAL PLACE MEADOR CEMETERY DATE 3/2 1940

19. FUNERAL DIRECTOR (NAME) LAUCKEL FUNERAL SERVICE
(ADDRESS) FRONTON MO.

20. FILED 3/5/ 1940 BC-Dunton
Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 2-29 1940

22. I HEREBY CERTIFY, That I attended deceased from Feb 19 1940, to Feb 25 1940

I last saw him alive on Feb 25 1940 Death is said to have occurred on the date stated above, at 5 P. m.

The principal cause of death and related causes of importance were as follows:

Goatitis

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? Yes

If so, specify Yes
(Signed) W. J. Dunton M. D.
(Address) Fronton, Mo.

WHITE PEARL, WITH UNFADING INK---THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully studied. 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.

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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 Geo. P. Lusk

Licensed Embalmer No. 3475

P. O. Address Quinton 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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **685-0**

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. **390**

Primary Registration District No. **55-45-**

Registrar's No. _____

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:

(a) County **Iron**
(b) City or town **Union**
(If outside city or town limits, write "RURAL" and name of township)
(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 _____ (Specify whether
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County _____
(c) City or town _____
(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) PRINTED FULL NAME **John Hiram Hamilton**

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

4. Sex **m** 5. Color or race **w** 6. (a) Single, widowed, married, divorced **m**

6. (b) Name of husband or wife _____ 6. (c) Age of husband, or wife, if alive _____ year

7. Birth date of deceased _____ (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
46 10 8 _____ hr _____ min.

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

10. Usual occupation _____

11. Industry or business _____

MOTHER { 12. Name _____

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

14. Maiden name _____ (City, town, or county) (State or foreign country)

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

16. (a) Informant _____

(b) Address _____

17. (a) _____ (b) Date thereof _____ (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (b) _____ (Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH Month **2** day **29**
year **1900** hour _____ minute _____ M.

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

Immediate cause of death **Gastritis**
Due to **no one knows**
Due to **acid non haemolytic**

Other conditions _____ (include pregnancy within 3 months of death)

Major findings: Of operations **1180**

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 **C. H. Jones** (M. D. or other) _____

Address **Frederick** _____

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

SUPPLEMENTAL COPY

S-6850

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