

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.

APR 12 1940  
Registration District No. 26

Primary Registration District No. 5034

Registrar's No. 30

1. PLACE OF DEATH:

(a) County Andrew  
(b) City or town near Mexico Mo.  
(c) Name of hospital or institution: Rural Salt River Twp  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution x (Specify whether years, months or days) 3 months

2. USUAL RESIDENCE OF DECEASED:

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 16<sup>th</sup>  
year 1940 hour 11 minute 55 A. M.  
21. I hereby certify that I attended the deceased from December 1<sup>st</sup> to March 6<sup>th</sup> 1940  
that I last saw her alive on February 24, 1940  
and that death occurred on the date and hour stated above.

Immediate cause of death: Acute Dilatation Heart  
Due to Mitral Insufficiency  
Due to Broken Coronary

Duration

Other conditions: 92 B  
(Include pregnancy within 3 months of death)

Major findings: Of operations  
Of autopsy: —  
PHYSICIAN: —  
Underline the cause to which death should be charged statistically.

8. (a) PRINT FULL NAME Mary Etta Hamilton  
8. (b) If veteran, name war x  
8. (c) Social Security No. x

4. Sex Female 5. Color or race white 6. (a) Single, widowed, married, divorced Wid  
6. (b) Name of husband or wife W. E. Hamilton 6. (c) Age of husband or wife if alive Dead years  
7. Birth date of deceased: (Month) Oct (Day) 30 (Year) 1866

8. AGE: Years 73 Months 4 Days 6 If less than one day hr. min.

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

10. Usual occupation Housewife

11. Industry or business Farmers wife

12. Name Calvin Baxter

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

14. Maiden name Eliza J. Clark

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

16. (a) Informant's own signature Calvin H. Sims

(b) Address Mexico Mo.

17. (a) Burial (b) Date thereof Mar. 8-40  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Auxvasse

18. (a) Signature of funeral director Hughes Manpin  
(Specify type of place)

(b) Address Auxvasse Mo.

19. (a) Mar 6 1940 (b) Blanche Neely  
(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 Fred Griffin (M. D. or other)  
Address 117 East Main St Date signed March 11/1940

RECEIVED

District Health Officer No. 10

District File Number 4-40-782

Date Filed APR 9 1940

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 Hughes Maupin  
Licensed Embalmer No. 235-8

P. O. Address Cent. Wash, 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

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

State File No. 10052

Registration District No. 26

Primary Registration District No. 5034

Registrar's No. 30

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

1. PLACE OF DEATH:

(a) County Andrew  
(b) City or town Salt River Sw. Rural  
(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)

3. (a) PRINT FULL NAME Mary Etta Hamilton

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

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

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband, or wife, if alive \_\_\_\_\_ years

7. Birth date of deceased \_\_\_\_\_ (Month) \_\_\_\_\_ (Day) \_\_\_\_\_ (Year)

8. AGE: Years 73 Months 4 Days 6 If less than one day \_\_\_\_\_ min.

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

10. Usual occupation \_\_\_\_\_

11. Industry or business \_\_\_\_\_

MOTHER FATHER { 12. Name \_\_\_\_\_  
13. Birthplace \_\_\_\_\_ (City, town, or county) \_\_\_\_\_ (State or foreign country)  
14. Maiden name \_\_\_\_\_  
15. Birthplace \_\_\_\_\_ (City, town, or county) \_\_\_\_\_ (State or foreign country)

16. (a) Informant \_\_\_\_\_  
(b) Address \_\_\_\_\_

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

18. (a) Signature of funeral director \_\_\_\_\_  
(b) Address \_\_\_\_\_

19. (a) March 7-1940 (b) B. Blanche Veely  
(Date received local registrar) (Registrar's signature)

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.

19. MEDICAL CERTIFICATION

20. DATE OF DEATH Month Mar day 6  
year 1940 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 \_\_\_\_\_  
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 Fred Griffin (M. D. or other) \_\_\_\_\_  
Address Mexico \_\_\_\_\_ Date signed \_\_\_\_\_

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

SUPPLEMENTARY

S-10052