

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

42553

State File No. _____

Registrar's No. 1029

Registration District No. 318

Primary Registration District No. 2001

1. PLACE OF DEATH:

(a) County Greene
 (b) City or town Springfield
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution: Springfield Baptist Hospital
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 1 day
(Specify whether years, months or days) 1

3. (a) PRINT FULL NAME Nora Hamilton
 (b) If veteran, name war No
 (c) Social Security No. None

4. Sex Female 5. Color or race White
 6. (a) Single, widowed, married, divorced Widowed
 6. (b) Name of husband or wife C.G. Hamilton
 6. (c) Age of husband or wife if alive Dec years
 7. Birth date of deceased January 27 - 1889
(Month) (Day) (Year)

8. AGE: Years 51 Months 10 Days 27
 If less than one day hr. min.

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

10. Usual occupation Housewife

11. Industry or business Home

MOTHER FATHER
 { 12. Name Creed Pruitt
 { 13. Birthplace Unknown Kentucky
(City, town, or county) (State or foreign country)
 { 14. Maiden name Melissa E. Hammond
 { 15. Birthplace Miller Co., Missouri
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Nora Hamilton
 (b) Address Niangna 500

17. (a) Burial (b) Date thereof Dec. 26-1940
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Niangna
 18. (a) Signature of funeral director W. E. Handley
 (b) Address Marshallfield, Mo.

19. (a) 12-26-40 (b) W. E. Handley
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Webster
 (c) City or town Rural-Niangna Township
(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 Dec. day 24
 year 1940 hour 6 minutes 30 P. M.
 21. I hereby certify that I attended the deceased from Death-1940
 _____, 19____, to Dec 24, 1940
 that I last saw her alive on Dec 24, 1940
 and that death occurred on the date and hour stated above.

Immediate cause of death Pneumococcal meningitis, extension from right
 Due to suppurative otitis media,
 Due to Post-influenzal
 Other conditions 11/12
(Include pregnancy within 3 months of death)

Major findings: 11/12
 Of operations _____
 Of autopsy None

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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? _____
(Specify type of place)
 While at work? _____ (e) Means of injury _____
 23. Signature W. E. Handley (M. D. or other) _____
 Address Niangna Mo. Date signed 12-25-40

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.

1 X1911

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 X

X X X X X, Registered Apprentice No. X
working under my personal supervision.

Signed J. J. [Signature]
Licensed Embalmer No. 3312
P. O. Address Marshfield, 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. X