

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **42867**

Registration District No. **411** Primary Registration District No. **2002** Registrar's No. _____

1. PLACE OF DEATH:
(a) County **Gascon**
(b) City or town **Gascon**
(c) Name of hospital or institution: **St John Hospital**
(d) Length of stay: In hospital or institution **4 days**
In this community **4 days**

2. USUAL RESIDENCE OF DECEASED:
(a) State **Missouri** (b) County **McDONALD**
(c) City or town **Noel**
(d) Street No. **0**
(e) If foreign born, how long in U. S. A.?

3. (a) PRINT FULL NAME **LORA LEE HAMILTON**
(b) If veteran, name war _____ (c) Social Security No. _____

4. Sex **Female** 5. Color or race **White** 6. (a) Single, widowed, married, divorced **Married**
(b) Name of husband or wife **FRANK HAMILTON** 6. (c) Age of husband or wife if alive **76** years
7. Birth date of deceased **MARCH 31 1876**

8. AGE: Years **64** Months **8** Days **9** If less than one day hr. _____ min. _____

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

10. Usual occupation **Housewife**

11. Industry or business _____
12. Name **R.F. Baxter**
13. Birthplace _____
14. Maiden name **Anna Marie Roberts**
15. Birthplace _____

16. (a) Informant **Mrs Earl Wharton**
(b) Address **Noel, Missouri**

17. (a) **Burial** (b) Date thereof **12/2/40**
(c) Place: burial or cremation **Freemans Cemetery**

18. (a) Signature of funeral director **Chas W. Williams**

(b) Address **Goodman Ave**
19. (a) **12-17-40** (b) **Ed J. Jones**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month **Dec** day **10**
year **1940** hour **5** minute **30 P.M.**
21. I hereby certify that I attended the deceased from **Dec 8**, 1940 to **Dec 10**, 1940;
that I last saw her alive on **Dec 10**, 1940;
and that death occurred on the date and hour stated above.

Immediate cause of death **Cerebral hemorrhage**
Duration **96 hrs**

Due to **Atherosclerosis**
Due to _____

Other conditions **Hypertension**
(Include pregnancy within 3 months of death)

PHYSICIAN
Major findings: _____
Of operations: _____
Of autopsy: _____
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? _____
(d) Did injury occur in or about home, on farm, in industrial place, in public place?
372 (Specify type of place) (e) Means of injury _____

23. Signature **J. J. [unclear]** (M. D. or other) **[unclear]**
Address **Franklin St** Date signed **Dec 7**

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

19
7
5

41-1-41

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.