

NOT WRITE

of Death City

stitution

idence County City

spitation

ident

er

er

of Death Day Year

ry Cause

a of Illness Mos. Days

ry Cause

ry Cause

eration

topsy

ident elapsed Days

f Accident

of Injury

of Injury

d to Occu.

Attendant

osition

I Director

an & War

Sec. No.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
APR 19 1941

U.S. DEPARTMENT OF HEALTH
Division of Vital Statistics

State Office No. 26344

805 Certificate of Death 4482

1. PLACE OF DEATH:

(a) County Schuyler Township Perry

(b) City or Town Glennwood Mo
(If outside city or town write RURAL NEAR and give town)

(c) Hospital or Institution: Name and Street Address

(d) Length of stay in Hospital or Inst. (yrs., or mos., or days)

In this community (yrs., or mos., or days) 10 yrs

2. USUAL RESIDENCE (HOME) OF DECEASED:
For newborn infant give residence of mother

(a) State Java (b) County Appanoose

(c) City or town Monavia Mo
(If outside city or town limits write RURAL NEAR and give town)

(d) Street No. 0
(If rural give LOCATION)

(e) If foreign born, how long in U. S. A. 2 years

3. (b) IF VETERAN, NAME WAR No

3. (a) FULL NAME Jessie Hamilton

3. (c) Social Security Account Number None

4. Sex 71

5. Color or Race W

6. (a) Single, married, widowed or divorced married

6. (b) Name of husband or wife W P Hamilton

6. (c) If alive, give age 88 years

7. Birth date of deceased (mo., day, yr.) May 14 - 1860

8. Age

Years	Months	Days	If less than 1 day
<u>80</u>	<u>10</u>	<u>29</u>	hrs. min.

9. Birthplace Appanoose Co Iowa
(Town, county, and state or foreign country)

10. Usual Occupation House wife

11. Industry or business

12. Name Abram Kimer

13. Birthplace (City, town or county) (State or foreign country) 9 no record

14. Name Ruth Frankham

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

16. (a) Informant's own signature Ruth Simons

(b) Address Glennwood Mo

17. (a) Burial, examination, or removal (specify) (b) Date thereof (Month) (Day) (Year)

(c) Place of burial or cremation W Pleasant Cemetery

Location Monavia County Iowa

18. (a) Signature O C Lewis

(b) Address Albany (c) License No. 1445

19. Signature W P Hamilton District 4

Local Registrar W P Hamilton

19. Signature W P Hamilton District 4

Date received May 10 - 1941 Filed No. 522

MEDICAL CERTIFICATION

20. DATE OF DEATH April 13 1941, at 10:00 AM (Month, WRITE OUT) (Day) (time)

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 1941 to April 13 1941, and that I saw her alive on April 13 1941

Immediate cause of death Inferiority of eye

Due to 97

Other conditions arterio-sclerosis

(Include pregnancy within 3 months of death)

OPERATION: Date of

Of operation

Of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide or homicide (b) Date of

(c) Where did injury occur? (City or town) (County) (State)

(d) Injured at home, farm, industry, public place (where?)

(e) Injured at work? (Yes or no)

(f) Means of injury

(g) Nature of injury

23. (a) Signature W P Hamilton (M. D. or other)

(b) Address Glennwood Mo

(c) Date signed April 14 - 1941

DURATION

PHYSICIAN

Please underline the cause to which the death should be ascribed

ADDITIONAL SPACE FOR FURTHER STATEMENTS
BY PHYSICIANS

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY LICENSED EMBALMERS

I, W. E. Lewis Licensed Embalmer No. 1443 hereby certify that
the body recorded on the reverse side of this certificate was embalmed by self L. E.
No. _____ or by _____ Registered student No. _____
working under my personal supervision.

Signed

W. E. Lewis

Licensed Embalmer No. 1443

NOTE: The above statement MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HAND WRITING.
(Failure to comply with the above constitutes grounds for revocation of license).

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 26344

Registration District No. 805

Primary Registration District No. 4482

Registrar's No. ?

1. PLACE OF DEATH:

(a) County Schwepher
(b) City or town Gleeswood
(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 _____
In this community 6 weeks 5 months (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Iowa (b) County Appanoose
(c) City or town Moravia
(If outside city or town limits, write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Jemittie Hamilton
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month April year 1941 hour _____ minute _____ M.
21. I hereby certify that I attended the deceased from _____, 19____; that I last saw him/her alive on _____, 19____; and that death occurred on the date and hour stated above.

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

Immediate cause of death _____ Duration _____

8. AGE: Years 80 Months _____ Days _____ If less than one day _____ min.

Due to _____
Due to _____
Other conditions (include pregnancy within 3 months of death) _____
Major findings: Of operations _____
Of autopsy _____

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

10. Usual occupation _____

11. Industry or business _____

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 14 14-41
(Burial, cremation, or removal) (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)

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? _____

While at work? _____ (Specify type of place) (e) Means of injury _____

23. Signature _____ (M. D. or other) _____
Address _____ Date signed _____

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

SUPPLEMENTARY

