

FILED AUG 18 1941

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

2641V  
Do not use this space.

1. PLACE OF DEATH  
 (a) County Sullivan Registration District No. 852  
 (b) Township Jackson Primary Registration District No. 6124  
 (c) City Melan (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.

2. PRINT FULL NAME Dora T Hamilton  
 (a) Residence, No. \_\_\_\_\_ St.  (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED Widowed  
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Arch F. Hamilton  
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) July 28, 1863  
 7. AGE YEARS 77 MONTHS 11 DAYS 14 If LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.  
 OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Housewife  
 9. Industry or business in which work was done, as saw mill, bank, etc. \_\_\_\_\_  
 10. Date deceased last worked at this occupation (month and year) July 1, 1940 11. Total time (years) spent in this occupation 50  
 12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Sullivan County  
 FATHER 13. NAME William Thomas Payne  
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Kentucky  
 MOTHER 15. MAIDEN NAME Olivia Conkin  
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Unknown  
 17. INFORMANT Mr. Thomas White  
 (ADDRESS) Melan, Mo  
 18. BURIAL, CREMATION, OR REMOVAL PLACE Home DATE 7-14 1941  
 19. FUNERAL DIRECTOR (NAME) Legg & Son  
 (ADDRESS) Melan, Mo  
 20. FILED Aug 9 1941 Wes Hagan  
 (Address) Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) July 12, 1941  
 22. I HEREBY CERTIFY That I attended deceased from May 9, 1941 to July 12, 1941  
 I last saw h. ER alive on July 11, 1941 Death is said to have occurred on the date stated above, at 1:40 P.M.  
 The principal cause of death and related causes of importance were as follows:  
Carcinoma of the  
stomach  
 Date of onset unknown  
 Other contributory causes of importance: HGB  
 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? \_\_\_\_\_  
 If so, specify \_\_\_\_\_  
 (Signed) H. G. Church M.D.  
 (Address) W. Sun City, Mo.

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.

1247 \* P. 01-1 (1937)

RECEIVED

District Health Officer No. 10

District File Number 8-41-1506

Date Filed AUG 13 1941

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 Lucas C. Riggan

Licensed Embalmer No. 3792

P. O. Address Milwaukee

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.

STANDARD CERTIFICATE OF DEATH

State File No. 26411

Registration District No. 852

Primary Registration District No. 6124

Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH:

(a) County Sullivan  
(b) City or town Jackson  
(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 \_\_\_\_\_)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Sullivan  
(c) City or town Boynton  
(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 Dora J. 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 wid

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 Months Days If less than one day min.

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) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)

(c) Place: burial or cremation

18. (a) Signature of funeral director

(b) Address

19. (a) Oct 8 1941 (b) (Cleo Hagan) (Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July 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.

Immediate cause of death \_\_\_\_\_ Duration \_\_\_\_\_

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

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)

(b) Did injury occur in or about home, on farm, in industrial place, in public place? \_\_\_\_\_

(Specify type of place) While at work? (c) Means of injury \_\_\_\_\_

23. Signature \_\_\_\_\_ (M. D. or other)

Address \_\_\_\_\_ Date signed \_\_\_\_\_

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

SUPPLEMENTARY

MOTHER FATHER

[The page contains extremely faint and illegible text, likely due to low contrast or poor scan quality. The text is arranged in several paragraphs across the page, but no specific words or phrases can be discerned.]