

No. 2
13-40
7-30
X231589

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

18782

State File No.

FILED JUN 11 1943 93

Primary Registration District No. 6005

Registrar's No.

1. PLACE OF DEATH:
(a) County Ralls
(b) City or town Frankford Mo.
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 1 Sooner Way
(If not in hospital or institution, write street number & location)
(d) Length of stay: In hospital or institution 40 years (Specify whether years, months or days)
In this community 40 years
3. (a) PRINT FULL NAME LIZA HAMILTON SEE
3. (b) If veteran, name war - 3. (c) Social Security No. -
4. Sex FEMALE 5. Color or race WHITE 6. (a) Single, widowed, married, divorced MARRIED
6. (b) Name of husband or wife J. MARRION SEE 6. (c) Age of husband or wife if alive 4 years
7. Birth date of deceased January 4 1943
(Month) (Day) (Year)

8. AGE: Years 65 Months 4 Days 13 If less than one day hr. min.

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

10. Usual occupation Housewife

11. Industry or business

MOTHER FATHER { 12. Name John Hamilton
13. Birthplace Missouri
(City, town, or county) (State or foreign country)
14. Maiden name Addie Davison
15. Birthplace Missouri
(City, town, or county) (State or foreign country)

16. (a) Informant J. Marion See

(b) Address Frankford Mo.

17. (a) Burial (b) Date thereof May 19 1943
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Frankford Mo.

18. (a) Signature of funeral director Richard L. See
(b) Address Frankford Mo.

19. (a) (Date received local registrar) (b) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Ralls 87
(c) City or town Frankford Mo. 0
(If outside city or town limits, write "RURAL")
(d) Street No. 0
(If rural, give location)
(e) If foreign born, how long in U. S. A. 0 years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 17
year 1943 hour 5:30 minute P M.

21. I hereby certify that I attended the deceased from June 17 1943 to May 17 1943
that I last saw him alive on April 20 1943
and that death occurred on the date and hour stated above.

Immediate cause of death Arteriosclerosis Duration

Due to

Due to

Other conditions Nephritis
(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 W. L. Jones (M. D. or other)
Address Frankford Mo. Date signed 5/19/43

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

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

1111

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED

District Health Officer No. 10

District File Number 6-43-1040

Date Filed JUN 9 1943

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

Jane Fielder Megowan

Licensed Embalmer No. 4093

P. O. Address

Franklin, 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, fact should be so stated above.

State File No. _____

Registrar's No. _____

(a) County Carroll
(b) City or town 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____
years, months or days)

3. (a) PRINT FULL NAME Lina Hamilton Lee

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 W

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 65 Months 4 Days 20 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 W

FA (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 _____
(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)

(a) State _____ (b) County _____

(c) City or town _____

(d) Street No. _____

(e) Citizen of foreign country?.....(Yes or No)

If yes, name country.

20. DATE OF DEATH: Month May day 27
year 1943 hour 12 minute 00 M

21. I hereby certify that I attended the deceased from _____

that Platt saw h... alive on 19

and that death occurred on the date and hour stated above.

Immediate cause of death arteriosclerosis Duration

Due to.....

Due to _____

Other conditions hypertensive disease
(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 on _____ (Specify type of place) _____
(e) Means of injury _____

23. Signature [Signature] M. D. (month) _____

Address Franklin Ave Date signed 6/17

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

LT E. Sija Hamilton Lee
 eran, _____
 war _____ No. _____
 3. (c) Social Security
 5. Color or _____
 race W
 6. (a) Single, widowed, married, _____
 divorced m
 of husband or wife _____
 6. (c) Age of husband or wife if _____
 alive _____ year _____
 e of deceased Jan _____
 (Month) _____ (Day) _____ (Year) _____
 Years _____ Months _____ Days _____
65 4 5
 If less than one day _____ min. _____
 (City, town, or county) _____
 (State or foreign country) Ms. _____
 or business _____
 place _____
 (City, town, or county) _____ (State or foreign country) _____
 en name _____

MEDICAL CERTIFICATION
 20. DATE OF DEATH: Month May 1943 year _____ hour _____ minute _____
 21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____,
 that I last saw him _____ alive on _____, 19____,
 and that death occurred on the date and hour stated above.
 Immediate cause of death arteriosclerosis
 Duration _____
 Due to _____
 Due to _____
 Other conditions nephritis chronic
 (Include pregnancy within 3 months of death)
 Major findings:
 Of operations _____
 Of autopsy _____
 PHYSICIAN _____
 Underlin
 the cause t
 which deat
 should b
 charged sta
 tistically.

O.W. Snodgrass m
Frankford, N

S 1021-2.