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DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. \_\_\_\_\_

Registrar's No. 160

FILED DEC 23 1943  
Registration District No. 320

Primary Registration District No. 6225

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

1. PLACE OF DEATH:

(a) County Wagon

(b) City or town Barry - Washington  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:  
State Hosp # 32  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 2 1/2 months  
(Specify whether  
In this community same  
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State MO (b) County Barry <sup>168</sup>

(c) City or town Peter  
(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. 0

3. (a) PRINT FULL NAME Elmer Milton Hamilton

3. (b) If veteran, name war No 3. (c) Social Security No. None

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

6. (b) Name of husband or wife Nellie Hamilton 6. (c) Age of husband or wife if alive 87 years

7. Birth date of deceased Dec 22 1881  
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>61</u>	<u>10</u>	<u>18</u>	_____ hr. _____ min.

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

10. Usual occupation Railroad

11. Industry or business \_\_\_\_\_

MOTHER FATHER { 12. Name S. Milton Hamilton

13. Birthplace Iowa  
(City, town, or county) (State or foreign country)

14. Maiden name Sarah Jane Dunn

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

16. (a) Informant Hoop Reed

(b) Address \_\_\_\_\_

17. (a) Removal (b) Date thereof 11-9-43  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Thayer Mo

18. (a) Signature of funeral director Color Funeral Home

(b) Address Thayer Mo

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov day 9 year 1943 hour 4 minute 10 P.M.

21. I hereby certify that I attended the deceased from Sept 6 1941 to Nov 19 1943 that I last saw him alive on Nov 8 1943 and that death occurred on the date and hour stated above.

Immediate cause of death \_\_\_\_\_  
Alzheimers Disease

Due to Gen. Atherosclerosis

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

Other conditions (Include pregnancy within 3 months of death) 84d

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

Of autopsy as above

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) \_\_\_\_\_ (c) Means of injury \_\_\_\_\_

23. Signature Mr. J. Greer (M. D. or other) \_\_\_\_\_

Address Yaboda Date signed 11/9/43

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

1331

RECEIVED

District Health Officer No. 71

District File Number

11-43-1300

Date Filed

12-6-43

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**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..... *Mark E. Schinger* .....

Licensed Embalmer No..... *2656* .....

P. O. Address..... *Nevada 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.**