S. No. 2
M—2-43
5-17-39
I X35697

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED FEB 28 1944

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 7415

Registration District No. 126 — Primary Registration District No. 2001 — Registrar's No. 85

1. PLACE OF DEATH:

(a) County: Jasper
(b) City or town: Joplin (If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: St Johns O (If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 48 Hrs. (Specify whether years, months or days)
In this community: Non Resident

2. USUAL RESIDENCE OF DECEASED:

(a) State: Kansas (b) County: Cherokee 999
(c) City or town: Galena 14 (If outside city or town limits, write "RURAL")
(d) Street No.: Galena Heights 0 (If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country: No 2

3. (a) PRINT FULL NAME: Frances Mildred Hamilton

3. (b) If veteran, name war: No

3. (c) Social Security No.: No

4. Sex: Female

5. Color or race: White

6. (a) Single, widowed, married, divorced: Married

6. (b) Name of husband ~~or wife~~: Clede Hamilton

6. (c) Age of husband or wife if alive: 36 years

7. Birth date of deceased: Oct. 22 (Month) 1916 (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
27	3	16	hr. min.

9. Birthplace: Galena (City, town, or county) Kan 1 (State or foreign country)
10. Usual occupation: House wife
11. Industry or business: At Home

FATHER
12. Name: Bess Webb
13. Birthplace: unknown 9 (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name: Manda Creighbaum
15. Birthplace: unknown 9 (City, town, or county) (State or foreign country)

16. (a) Informant: Clede Hamilton
(b) Address: Galena Kan
17. (a) Removal (Burial, cremation, or removal) (b) Date thereof: 2/8-44 (Month) (Day) (Year)
(c) Place: burial or cremation: Galena Kan
18. (a) Signature of funeral director: Frank Allison
(b) Address: Galena Kan
19. (a) 2-11-44 (Date received local registrar) (b) Gertrude Sudhoeller (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb day 8 year 1944 hour 7 minute P M.

21. I hereby certify that I attended the deceased from 2/7/44, 19__ to 2/8/44, 19__; that I last saw her alive on 2/8/44, 19__; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Meningococcus Meningitis	
Due to: Meningococcus Diplococcus	
Due to:	
Other conditions (Include pregnancy within 3 months of death): 6	
Major findings: Of operations:	
Of autopsy: yes	

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? (Specify type of place)
While at work? (e) Means of injury: 0

23. Signature: Ernest Johnson (M.D. or other)
Address: 617 Frisco Bldg Date signed: 2/10/44

(Licensed Embalmer's Statement on Reverse Side)

44-2-142

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 Removed to Galva Kan, Registered Apprentice No. ....., working under my personal supervision. Before Emb -

Signed Frank Allison

Kan Licensed Embalmer No. 1321

P. O. Address Galva Kan

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.