

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS  
**FILED AUG 1 1946** **STANDARD CERTIFICATE OF DEATH**

24312

State File No. \_\_\_\_\_  
Registrar's No. 204

Registration District No. 209 Primary Registration District No. 3042

1. PLACE OF DEATH:  
(a) County Marion  
(b) City or town Hannibal  
(c) Name of hospital or institution:  
Lovering Hospital  
(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

2. USUAL RESIDENCE OF DECEASED:  
(a) State Missouri (b) County Marion 64  
(c) City or town Hannibal  
(If outside city or town limits, write "RURAL") 3  
(d) Street No. 1107 Fulton  
(If rural, give location) 4  
(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No) 0  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Elva Louise Hamilton  
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 Lloyd Wm. Hamilton 6. (c) Age of husband or wife if alive 45 years  
7. Birth date of deceased January 1, 1910  
(Month) (Day) (Year)

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month June day 1  
year 1946 hour 6 minute 55 A.M.  
21. I hereby certify that I attended the deceased from Jan 1942 to June 4, 1946  
that I last saw him alive on June 4, 1946  
and that death occurred on the date and hour stated above.  
Immediate cause of death Myelitis  
Duration 5 yrs

8. AGE: Years Months Days If less than one day  
36 5 7 hr. min.

Due to \_\_\_\_\_  
Due to \_\_\_\_\_  
Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_

9. Birthplace Hannibal Missouri  
(City, town, or county) (State or foreign country)  
10. Usual occupation Housewife  
11. Industry or business XX

Major findings: Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_  
ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED  
PHYSICIAN \_\_\_\_\_  
Underline the cause to which death should be charged statistically.

MOTHER FATHER { 12. Name Charles R. Mahan  
13. Birthplace Ripley West Virginia  
(City, town, or county) (State or foreign country)  
14. Maiden name Orpha Barnett  
15. Birthplace Cameron West Virginia  
(City, town, or county) (State or foreign country)

16. (a) Informant Lloyd W. Hamilton  
(b) Address 1107 Fulton Hannibal Missouri  
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/6/46  
(Month) (Day) (Year)  
(c) Place: burial or cremation Grandview Burial Park

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? \_\_\_\_\_

18. (a) Signature of funeral director Crawford Smith  
(b) Address 902 Broadway Hannibal Missouri  
19. (a) 6-7-46 (Date received local registrar) (b) Dr. E. M. Lucke (Registrar's signature)

While at work \_\_\_\_\_ (Specify type of place) (c) Means of injury \_\_\_\_\_  
23. Signature [Signature] (M. D. or other) \_\_\_\_\_  
Address [Address] Date signed \_\_\_\_\_

187

June 8 - 46

**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 *Charles Smith*  
Licensed Embalmer No..... 2914  
P. O. Address..... Hannibal Missouri

**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.**

Registration District No. 209 Primary Registration District No. 3043

1. PLACE OF DEATH:  
(a) County Marion  
(b) City or town Hammil  
(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 Elna I. 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 \_\_\_\_\_  
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 36 Months 5 Days \_\_\_\_\_ (Unless 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) \_\_\_\_\_ (b) Date thereof \_\_\_\_\_ (Month) (Day) (Year)  
(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_  
(b) Address \_\_\_\_\_

19. (a) \_\_\_\_\_ (b) \_\_\_\_\_  
(Date received local registration) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:  
(a) State \_\_\_\_\_ (b) County \_\_\_\_\_  
(c) City or town \_\_\_\_\_ (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 \_\_\_\_\_

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month Jan year 1946 minute \_\_\_\_\_ M.  
21. I hereby certify that I attended the deceased from \_\_\_\_\_ 19\_\_\_\_;  
that I last saw him \_\_\_\_\_ live on \_\_\_\_\_ 19\_\_\_\_;  
and that death occurred on the date and hour stated above.

Immediate cause of death: Chronic pleurisy  
Due to \_\_\_\_\_  
Due to \_\_\_\_\_

Other conditions \_\_\_\_\_ (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 \_\_\_\_\_  
21. Signature [Signature] (M. D. or other) \_\_\_\_\_  
Address \_\_\_\_\_ Date signed Aug 11 1946

SUPPLEMENTARY

WHILE FILLING IN—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

23165

24312