

DEPARTMENT OF HEALTH  
STATE OF MISSOURI  
CENSUS  
FILED DEC 24 1946  
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STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

41130

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

Registration District No. 170

Primary Registration District No. 3033

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

1. PLACE OF DEATH:

(a) County LACLEDE  
(b) City or town LEBANON  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: WALLACE HOSPITAL  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 7 DAYS  
In this community 15 YRS  
years, months or days (Specify whether)

2. USUAL RESIDENCE OF DECEASED:

(a) State MO (b) County LACLEDE  
(c) City or town RURAL  
(If outside city or town limits, write "RURAL")  
(d) Street No. LEBANON PLATO RT.  
(If rural, give location)  
(e) Citizen of foreign country? NO (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME

HAMILTON A. RILEY

3. (b) If veteran, name war \_\_\_\_\_

3. (c) Social Security No. \_\_\_\_\_

4. Sex M Color or race W

5. Color or race W

6. (a) Single, widowed, married, divorced WIDOWER

6. (b) Name of husband or wife EVA WICOXON

6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased DEC (Month)

8 (Day) 1969 (Year)

8. AGE: Years 77 Months - Days 9

If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_

9. Birthplace MERCER Co (City, town, or county)

MO (State or foreign country)

10. Usual occupation FARMER

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

12. Name P.O.T. RILEY

13. Birthplace RILEY Co (City, town, or county)

IOWA (State or foreign country)

14. Maiden name SARAH LOVE

15. Birthplace RILEY Co (City, town, or county)

IOWA (State or foreign country)

16. (a) Informant Mr. R. Riley

(b) Address LEBANON MO

17. (a) REMOVAL (Burial, cremation, or removal)

(b) Date thereof 12-18-46 (Month) (Day) (Year)

(c) Place: burial or cremation MINNEAPOLIS, IOWA

18. (a) Signature of funeral director PALMER'S

(b) Address LEBANON MO

19. (a) Dec 21 1946 (Date received local registrar)

(b) Geo. Jamburg (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month DEC day 17 year 1946 hour 3 minute 30 P. M.

21. I hereby certify that I attended the deceased from Nov 15, 1944 to Dec 17, 1946, that I last saw him alive on Dec 17, 1946, and that death occurred on the date and hour stated above.

Immediate cause of death: Adenocarcinoma of pancreas with metastatic growth in liver, lung, heart, abdominal and pelvic glands.

Other conditions (include pregnancy within 3 months of death) None

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

Of autopsy findings 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? \_\_\_\_\_

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

23. Signature James D. Hope (M. D. or other) Address: Lebanon, Mo. Date signed 12/17/46

Duration

1 1/2 yrs

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

12/26/46

Received .....

Laclede County Health Unit

File No. .... 12-46-177

Date Filed ..... 12/25/46

**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..... *R. D. Palmer* .....

Licensed Embalmer No. *1161* .....

P. O. Address: *Lamar 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.**