

FILED JUN 26 1947

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 20016

20016

Registration District No. 1

Primary Registration District No. 5004

Registrar's No. 165

1. PLACE OF DEATH:

(c) County Adair
(b) City or town "Rural"
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Chariton River, near Novinger 3
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution None
(Specify whether
In this community Life
years, months or days)

3. (a) PRINT FULL NAME Sarah Colleen Hamilton

3. (b) If veteran, name war _____ 3. (c) Social Security No. 497-30-8494

4. Sex F / 5. Color or race W 6. (a) Single, widowed, married, divorced Single

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased March 12 1930
(Month) (Day) (Year)

8. AGE: Years 17 Months 2 Days 14
If less than one day hr. _____ min. _____

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

10. Usual occupation Employee

11. Industry or business Kirksville Locker Store

12. Name Glen A. Hamilton

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

14. Maiden name Janie Casstevens

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

16. (a) Informant Glen Hamilton

(b) Address Kirksville, Missouri

17. (a) Burial (b) Date thereof 6/10/47
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Maple Hills Cmt.

18. (a) Signature of funeral director D. E. Riley

(b) Address Kirksville, Missouri

19. (a) 6-17-47 (b) Kate Lambert
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Adair
(c) City or town Kirksville
(If outside city or town limits, write "RURAL")
(d) Street No. 1116 South Ann
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 6
year 1947 hour 9 minute 07 P. M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;
that I last saw h _____ alive on _____, 19____,
and that death occurred on the date and hour stated above.

Immediate cause of death in swimming while wading in Chariton River overflow near Novinger, Mo
Due to _____

Due to _____

Other conditions (Include pregnancy within 3 months of death) _____

Major findings: Of operations _____

Of autopsy _____

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) accident

(b) Date of occurrence June 6, 1947

(c) Where did injury occur? near Novinger, Mo
(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) (g) Means of injury _____

23. Signature Fred T. Early (M. D. or other) _____

Address Branch, Mo. Date signed 6-8-47

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

MOTHER FATHER

RECEIVED

District Health Officer No. 10

District File Number - 6-47-286

Date Filed - JUN 24 1947

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.....

Kenneth Slavens

....., Registered Apprentice No. 418

working under my personal supervision.

Signed.....

D. E. Riley

Licensed Embalmer No. 4181

P. O. Address. Kirksville, 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.