

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

35389

FILED OCT 22 1947

Registration District No. 277

Primary Registration District No. 6022

State File No. _____

Registrar's No. 101

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

1. PLACE OF DEATH:

(a) County Ray

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

(c) Name of hospital or institution:
R.F.D. #1 3 miles W. Hickory - Robinson
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____
(Specify whether years, months or days)

In this community _____
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Ray

(c) City or town Rural
(If outside city or town limits, write "RURAL")

(d) Street No. 3 miles W. Hickory
(If rural, give location)

(e) Citizen of foreign country? _____ (Yes or No)

If yes, name country _____

3. (a) PRINT FULL NAME RUFUS MARION HAMAR

3. (b) If veteran, name war None

3. (c) Social Security No. none

4. Sex Male 5. Color or race W

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

6. (b) Name of husband or wife Single

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

7. Birth date of deceased Sept 25 1869
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day

77 11 24 _____ hr. _____ min.

9. Birthplace Ray Co Mo
(City, town, or county) (State or foreign country)

10. Usual occupation Farmer

11. Industry or business Farming

MOTHER FATHER

12. Name Wm. L. Hamar

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

14. Maiden name Maudie Cullahan

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

16. (a) Informant John L. Hamar

(b) Address Rayville R.F.D. #1

17. (a) Burial (b) Date thereof 9/20/47
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Hickory Cemetery

18. (a) Signature of funeral director Sept 29 1947

(b) Address Richmond, Mo.

19. (a) Sept 29 - 1947 (b) M. J. J. J. J.
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept day 18
year 1947 hour 8 minute 10 M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;

that I last saw him _____ alive on _____, 19____;

and that death occurred on the date and hour stated above.

Immediate cause of death Bronchopneumonia

Duration 6 days

Due to Gun shot wound of chest self inflicted 10 day

Due to _____

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

PHYSICIAN

Major findings: _____

Of operations _____

Of autopsy _____

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) Suicide

(b) Date of occurrence 9-9-47

(c) Where did injury occur? Rayville Ray Mo.
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?
Home

While at work? No (Specify type of place)

(e) Means of injury Gunshot

23. Signature Shes J. J. J. (M. D. or D.O.)

Address Richmond, Mo. Date signed 9-29-47

RECEIVED

District Health Officer No. 8,

District File Number -----

Date Filed 10-20-47

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 *George Phil*

Licensed Embalmer No. 4466

P. O. Address *Richmond, Va.*

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.