

FILED SEP 29 1948
Registration District No. **94**

Primary Registration District No. **3056**

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

1. PLACE OF DEATH:
(a) County **Randolph**
(b) City or town **Prober**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: **M. Connick Hospital**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **Two days**
(Specify whether
In this community **Entire life**
years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State **Missouri** (b) County **Randolph**
(c) City or town **Prober**
(If outside city or town limits, write "RURAL")
(d) Street No. **119 S. Williams**
(If rural, give location)
(e) Citizen of foreign country? **No** (Yes or No)
If yes, name country.....

3. (a) PRINT FULL NAME **MADA CARL HAMILTON**
3. (b) If veteran, name war **None** 3. (c) Social Security No. **None**
4. Sex **Female** 5. Color or race **White** 6. (a) Single, widowed, married, divorced **9**
6. (b) Name of husband or wife..... 6. (c) Age of husband or wife if alive **years**
7. Birth date of deceased **December - 19 - 1890**
(Month) (Day) (Year)

8. AGE: Years **57** Months **9** Days **0** If less than one day
hr. min.

9. Birthplace **Prober, Ind.** (City, town or county) (State or foreign country)
10. Usual occupation **Beauty Shop**
11. Industry or business **Betty Beauty Shop**
12. Name **Carl Volgelrich**
13. Birthplace **Germany** (City, town or county) (State or foreign country)
14. Maiden name **Elizabeth Suppe**
15. Birthplace **New Franklin, Ind.** (City, town or county) (State or foreign country)
16. (a) Informant **Mr. J.B. Cross**
(b) Address **119 S. Williams Prober, Mo.**
17. (a) Burial, cremation, or removal **Burial** (b) Date there **Sept - 27 - 48**
(Month) (Day) (Year)
(c) Place: burial or cremation **Prober, Mo.**
18. (a) Signature of funeral director **Snow Funeral Home**
(b) Address **Prober, Missouri**
19. (a) Date received local registrar **Sept 21 - 48** (b) Registrar's signature **Gal Williams**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month **September** Day **19**
year **1948** hour **4** minute **00** A.M.
21. I hereby certify that I attended the deceased from **Sept 1**, 19 **48**, to **Sept 19**, 19 **48**
that I last saw him alive on **Sept 18**, 19 **48**
and that death occurred on the date and hour stated above.

Immediate cause of death **Myocardial Failure**
Brain Tumor
Due to **Encephalitis**
Other conditions (Include pregnancy within 3 months of death)
Major findings: **579**
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 **2**
23. Signature **J. J. Hammett** (M. D. or other) **Do**
Address **Prober** Date signed **9-20-48**

MOTHER FATHER

Duration

PHYSICIAN

Underline the cause of which death should be charged statistically.

RECEIVED
District Health Officer No. 10
District File Number 9.48.1685
Date Filed SEP. 28 1948

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. M. Carter

Licensed Embalmer No. _____

4117

P. O. Address _____

Mothers MD

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.