

FILED JAN 11 1949 318

Registration District No.

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

1003

41498
State File No. 11008
Registrar's No.

Primary Registration District No.

1. PLACE OF DEATH:

(a) County St. Louis, Missouri
(b) City or town St. Louis
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution Enroute to City Hospital 3
(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)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County gov
(c) City or town St. Louis
(If outside city or town limits, write "RURAL")
(d) Street No. 118 North Broadway
25 (If rural, give location)
(e) Citizen of foreign country?..... (Yes or No)
If yes, name country.....

3. (a) PRINT FULL NAME John J. Hamilton

3. (b) If veteran No 3. (c) Social Security No. 496-16-5976
name war.....

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Widowed
6. (b) Name of husband or wife Mattie Hamilton 6. (c) Age of husband or wife if alive..... years
7. Birth date of deceased February 12 1876
(Month) (Day) (Year)

8. AGE: Years 72 Months 10 Days 5 If less than one day
hr. min.

9. Birthplace Petersburg Illinois
(City, town, or county) (State or foreign country)

10. Usual occupation Assistant room clerk

11. Industry or business Meyers Hotel

MOTHER FATHER
12. Name Hobart Hamilton
13. Birthplace Vermont
(City, town, or county) (State or foreign country)
14. Maiden name Clara McDougall
15. Birthplace Ava New York
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Kathleen Webster
(b) Address Richmond, Virginia
17. (a) Cremation (b) Date thereof 12/20/48
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Valhalla Crematory

18. (a) Signature of funeral director Albert H. Hoppe
(b) Address 4700 Washington Blvd
19. (a) 20 1949 (b) J. B. Sander
(Date filed local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month December day 17
year 1948 hour 5 minute 00 P. A. 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. Duration

Immediate cause of death Chronic Myocarditis
arteriosclerotic
Chronic Unilateral Nephritis

Due to.....
Due to.....

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

PHYSICIAN
Major findings:
Of operations.....
Of autopsy.....
Underline the cause of which death should be charged statistically.

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?..... (Specify type of place)
While at work?..... (e) Means of injury.....

23. Signature [Signature] (M. D. or other)
Address [Address] Date signed [Date]

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

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..... **NO EMBALM**

Licensed Embalmer No.....

P. O. Address.....

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.