

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

8295

FILED APR 10 1950

State File No.

BIRTH NO. REG. DIST. NO. 128 PRIMARY REG. DIST. NO. 2000 Registrar's No. 315

1. PLACE OF DEATH a. COUNTY Greene		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Greene	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Springfield		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Springfield	
c. LENGTH OF STAY (in this place) 20 Yrs		d. STREET ADDRESS (If rural, give location) 1340 South Fort	
d. FULL NAME OF HOSPITAL OR INSTITUTION South Fort			

3. NAME OF DECEASED (Type or Print) a. (First) William b. (Middle) Thomas c. (Last) Hamilton			4. DATE OF DEATH (Month) (Day) (Year) March 31, 1950		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH Sept. 11, 1874	9. AGE (In years last birthday) 75	IF UNDER 1 YEAR Months 6 Days 20
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Farmer	11. BIRTHPLACE (State or foreign country) Ill.	12. CITIZEN OF WHAT COUNTRY? U.S.A.	

13a. FATHER'S NAME Henry H. Hamilton	13b. MOTHER'S MAIDEN NAME Mary Nichols	14. NAME OF HUSBAND OR WIFE Rosa Vienna Hamilton
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No	16. SOCIAL SECURITY NO. No	17. INFORMANT'S SIGNATURE OR NAME Walter Hamilton, 1340 S. Fort,	ADDRESS 1340 S. Fort,
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
	I. DIRECTLY LEADING TO DEATH* (a) Uremia		10 yrs
ANTECEDENT CAUSES Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last.		DUE TO (b) Hypertension, bi-	10 yrs
		DUE TO (c) contraction vesical neck	10 yrs
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		urinary bladder	60 IX

19a. DATE OF OPERATION 2-8-50	19b. MAJOR FINDINGS OF OPERATION CONTR. neck vesical neck.	20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
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21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from **12-20, 1949**, to **3-31, 1950**, that I last saw the deceased alive on **3-31, 1950**, and that death occurred at **4:45 P.M.**, from the causes and on the date stated above.

23a. SIGNATURE (Typed or title) W. S. Handley M.D.	23b. ADDRESS Springfield, Mo.	23c. DATE SIGNED 4-1-50
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 4-2-50	24c. NAME OF CEMETERY OR CREMATORY New Hope	24d. LOCATION (City, town, or county) (State) New Bremen Mo.
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DATE REC'D BY LOCAL REG. 4-3-50	REGISTRAR'S SIGNATURE W.S. Handley M.D.	25. FUNERAL DIRECTOR'S SIGNATURE W. S. Handley	ADDRESS Springfield, Mo.
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

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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 _____

..... Student Embalmer No.

working under my personal supervision.

Signed..... *R. J. McCann*

Signed.....
Student Embalmer

Licensed Embalmer No. *2727*

P. O. Address *Springfield 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.