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

FILED JUL 3 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

Dr Hamilton

State File No. 22528

BIRTH NO. _____ REG. DIST. NO. 355 PRIMARY REG. DIST. NO. 4520 Registrar's No. _____

1. PLACE OF DEATH
a. COUNTY: Texas
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Summersville
c. LENGTH OF STAY (In this place): 25 yrs
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location):

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Mo.
b. COUNTY: Texas 1070
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Summersville 0
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print)
a. (First): Gunder
b. (Middle):
c. (Last): Vaage

4. DATE OF DEATH (Month) (Day) (Year): June 14-50

5. SEX: M 0
6. COLOR OR RACE: W
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married /
8. DATE OF BIRTH: Sept 14-1884
9. AGE (In years last birthday): 66 — If under 1 year: Months 9, Days 0 — If under 24 hrs.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farming
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): 4 Hoggison, Norway
12. CITIZEN OF WHAT COUNTRY?: USA

13a. FATHER'S NAME: Andrew Vaage
13b. MOTHER'S MAIDEN NAME: Martha Hanson
14. NAME OF HUSBAND OR WIFE: Nettie Vaage

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no
(If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT'S SIGNATURE OR NAME / **ADDRESS**: Mrs G Vaage Summersville, Mo.

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, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b) Arterial Hypertension

DUE TO (c) Chronic Valvular Disease

II. OTHER SIGNIFICANT CONDITIONS — *Conditions contributing to the death but not related to the disease or condition causing death.* 331X

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

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 ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?:

22. *I hereby certify that I attended the deceased from* April 2, 1950, *to* June 13, 1950, *that I last saw the deceased alive on* June 13, 1950 *and that death occurred at* 2 a m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Dr Laurence Hamilton D.O.
23b. ADDRESS: Summersville
23c. DATE SIGNED: June 19

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 6-15-50
24c. NAME OF CEMETERY OR CREMATORY: Bethyl
24d. LOCATION (City, town, or county) (State): Summersville, Mo.

DATE REC'D BY LOCAL REG.: 6/21-50
REGISTRAR'S SIGNATURE: Anna Roberts 435
25. FUNERAL DIRECTOR'S SIGNATURE / **ADDRESS**: Duncan Funeral Home Mtn View, Mo

(Licensed Embalmer's Statement on Reverse Side)

6-26-32

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 Joe R. Duncan

Signed _____ Student Embalmer

Licensed Embalmer No. 4325T

P. O. Address Mtn. View, 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.