

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **41163**

FILED JAN 3 - 1952

BIRTH NO. --- REG. DIST. NO. **107** PRIMARY REG. DIST. NO. **3019** Registrar's No. **159**

1. PLACE OF DEATH a. COUNTY Franklin		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Mo b. COUNTY Franklin	
b. CITY (If outside corporate limits, write RURAL and give township) Kennett		c. CITY (If outside of corporate limits, write RURAL and give township) Kennett 03520	
c. LENGTH OF STAY (In this place) 45 yrs		d. STREET ADDRESS (If rural, give location) 7106.5 th. St	
d. FULL NAME OF HOSPITAL OR INSTITUTION 710.65 Home			

3. NAME OF DECEASED (Type or Print) JOHN. BELL. HAMILTON.			4. DATE OF DEATH (Month) (Day) (Year) 12/24-1951		
a. (First)	b. (Middle)	c. (Last)	5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married
8. DATE OF BIRTH 5/29/1860	9. AGE (In years last birthday) 91	IF UNDER 1 YEAR Months	IF UNDER 1 YEAR Days	IF UNDER 2 HRS. Hours	IF UNDER 2 HRS. Min.
10a. USUAL OCCUPATION (Give kind of work done during most working life, even if retired) Retail Farmer			10b. KIND OF BUSINESS OR INDUSTRY		
11. BIRTHPLACE (State or foreign country) Dixie Tenn			12. CITIZEN OF WHAT COUNTRY? USA		

13a. FATHER'S NAME unknown		13b. MOTHER'S MAIDEN NAME unknown		14. NAME OF HUSBAND OR WIFE Mary Hamilton	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Name		17. INFORMANT'S SIGNATURE OR NAME Anna Jones Nellyville Mo	
				ADDRESS	

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)		MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Coronary Occlusion		DUE TO (b) myocardial Degeneration			2 hours
*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			3 months

19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
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)		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 **June 10 1951**, to **Dec 24**, 1951, that I last saw the deceased alive on **Dec 24**, 1951, and that death occurred at **2:25 pm**, from the causes and on the date stated above.

23a. SIGNATURE Dr. J. W. D. ...		23b. ADDRESS Kennett Mo		23c. DATE SIGNED 12-26-51	
24a. BURIAL, CREMATION, REMOVAL		24b. DATE 12/26/1951		24c. NAME OF CEMETERY OR CREMATORY Oak Ridge	
24d. LOCATION (City, town, or county) (State)		24e. NAME OF FUNERAL HOME Emerson & Son		24f. ADDRESS Jennett Mo	
DATE REC'D BY LOCAL REG. 12-26-51		REGISTRAR'S SIGNATURE Carl Husband		25. FUNERAL DIRECTOR'S SIGNATURE Emerson & Son	
				ADDRESS	

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

RECEIVED DUNKLIN COUNTY HEALTH

DEPARTMENT 12-29-51

COUNTY FILE NUMBER 1251-265

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.

Student

Student Embalmer

Signed

James H. Jones

Licensed Embalmer No. 895

P. O. Address James H. Jones

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.