No. 300
10.48

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THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 10036

BIRTH NO. _____ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. 3006

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

1. PLACE OF DEATH
a. COUNTY
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): St Louis
c. LENGTH OF STAY (In this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 2815 TEXAS

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Mo
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): St Louis 2249
d. STREET ADDRESS (If rural, give location): 2815 TEXAS AV

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

4. DATE OF DEATH (Month) (Day) (Year): March-30-52

5. SEX: F
6. COLOR OR RACE: W
7. MARRIED, ~~NEVER MARRIED, WIDOWED, DIVORCED~~ (Specify): M
8. DATE OF BIRTH: Oct 18-1894
9. AGE (In years last birthday): 57 — If under 1 year: Months, Days — If under 24 hrs.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (City and State or Foreign Country): MILLSTADT ILL
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13a. FATHER'S NAME: KARL VOGEL
13b. MOTHER'S MAIDEN NAME: CHARLOTTE HEINRICH
14. NAME OF ~~HUSBAND OR~~ WIFE: GEORGE Hamilton

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown):
(If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT'S SIGNATURE OR NAME: George Hamilton — ADDRESS: 2815 Texas Av

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) Arteriosclerotic Heart Disease — INTERVAL BETWEEN ONSET AND DEATH: 1 year

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Arteriosclerosis — 1 years
DUE TO (c)

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

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):
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR? Fall

22. *I hereby certify that I attended the deceased from* Jan 1, 1952, *to* March 29, 1952, *that I last saw the deceased alive on* 3/29, 1952, *and that death occurred at* 32 m., *from the causes and on the date stated above.*

23a. SIGNATURE: B. J. McGinnis (Degree or title) MD
23b. ADDRESS: 16 Hampton Village Rd
23c. DATE SIGNED: 3/31/52

24a. BURIAL, CREMATION, REMOVAL (Specify): REMOVAL
24b. DATE: APRIL-1-52
24c. NAME OF CEMETERY OR CREMATORY: NEW St. Marcus
24d. LOCATION (City, town, or county) (State): St Louis Co. Mo

DATE REC'D BY LOCAL REG.: MAR 31 1952
REGISTRAR'S SIGNATURE: J Carl Smith MD
25. FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS: E. J. Schmer 3125 Lafayette Av

MGC (Licensed Embalmer's Statement on Reverse Side)

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 _____

Licensed Embalmer No. 4014

P. O. Address 312 S Lafayette

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.