

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **30793**  
Registrar's No. **1067**

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. **42** PRIMARY REG. DIST. NO. **1000**

1. PLACE OF DEATH a. COUNTY <b>Buchanan</b>		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <b>Mo.</b> b. COUNTY <b>Atchison</b>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>St. Joseph</b>	c. LENGTH OF STAY (in this place) <b>4 1/2 yrs in 7 mos</b>	c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>Rockport</b> <b>MO 30</b>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>State Hospital # 2</b>		d. STREET ADDRESS (If rural, give location) <b>Rural</b>	

3. NAME OF DECEASED (Type or Print) <b>Latie</b>	a. (First)	b. (Middle) <b>M.</b>	c. (Last) <b>HAMILTON</b>	4. DATE OF DEATH (Month) (Day) (Year) <b>10 8 1952</b>
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5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Married</b>	8. DATE OF BIRTH <b>unk.</b>	9. AGE (In years last birthday) <b>78</b>	IF UNDER 1 YEAR Months	IF UNDER 1 MIN. Days	IF UNDER 1 MIN. Hours	IF UNDER 1 MIN. Mins.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>at home</b>	11. BIRTHPLACE (State or foreign country) <b>Mersey Tenn</b>	12. CITIZEN OF WHAT COUNTRY? <b>America</b>
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13a. FATHER'S NAME <b>Kath B. Strames</b>	13b. MOTHER'S MAIDEN NAME <b>Ella Long</b>	14. NAME OF HUSBAND OR WIFE <b>Thimbleton Hamilton</b>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (If no, unknown) (If yes, give war or dates of service) <b>No</b>	16. SOCIAL SECURITY NO. <b>Rel</b>	17. INFORMANT'S SIGNATURE OR NAME <b>Thimbleton Hamilton</b>	ADDRESS <b>Rockport Mo</b>
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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 <b>10-2-1952</b>
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Brain hemorrhage</b>		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <b>Cerebral arteriosclerosis 10 yrs</b>		
DUE TO (c) <b>Senile psychosis</b>		4 yrs +	

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION <b>331X</b>	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" 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)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
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22. I hereby certify that I attended the deceased from **10-2-1952**, to **10-8-1952**, that I last saw the deceased alive on **10-7-1952**, and that death occurred at **2:30 a.m.**, from the causes and on the date stated above.

23a. SIGNATURE <b>E. Cassius MD</b>	(Degree or title)	23b. ADDRESS <b>State Hospital # 2</b>	23c. DATE SIGNED <b>10-8-1952</b>
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24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE <b>10/8/1952</b>	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State) <b>Rockport Missouri</b>
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DATE REC'D BY LOCAL REG. <b>Oct 9, 1952</b>	REGISTRAR'S SIGNATURE <b>Carl C. Carter</b>	25. FUNERAL DIRECTOR'S SIGNATURE <b>Horton-Broman</b>	ADDRESS <b>Funeral Home St. Joseph, Mo.</b>
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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 \_\_\_\_\_

working under my personal supervision.

Student Embalmer No. ....

Signed.....  
Student Embalmer

Signed: Eugene Wood

Licensed Embalmer No. 3804

P. O. Address 219 So 10th St. Joseph, 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.