No. 300
0.48

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

FILED OCT 13 1953

State File No. 31421

BIRTH NO. _____ REG. DIST. NO. 104 PRIMARY REG. DIST. NO. 4176 Registrar's No. 28

1. PLACE OF DEATH
a. COUNTY: Dunklin
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Malden
c. LENGTH OF STAY (in this place): 1 mo.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 206 E Laclede

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Mo.
b. COUNTY: Pemiscot
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Bragadocia
d. STREET ADDRESS (If rural, give location): 0780 1

3. NAME OF DECEASED (Type or Print): a. (First) EMERSON b. (Middle) L. c. (Last) HAMELBACK

4. DATE OF DEATH (Month) 10 (Day) 2 (Year) 53

5. SEX: M O
6. COLOR OR RACE: W
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed
8. DATE OF BIRTH: 9-7-1881
9. AGE (In years last birthday): 72 — 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): Farmer
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Missouri
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13a. FATHER'S NAME: Joe HAMELBACK
13b. MOTHER'S MAIDEN NAME: Unknown
14. NAME OF HUSBAND OR WIFE:

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.: No.
17. INFORMANT'S SIGNATURE OR NAME: Joe Hamelback — ADDRESS: 206 E. Laclede Malden, 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) Cancer of Stomach — INTERVAL BETWEEN ONSET AND DEATH: 1 yr

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
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: 151 X
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* Feb 15, 1953, *to* Oct 2, 1953 *that I last saw the deceased alive on* Oct 2, 1953 *and that death occurred at* 11.45 *p.m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): J. Carlstrom D.O.
23b. ADDRESS: Malden Mo
23c. DATE SIGNED: 10-3-53

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: Oct. 5, 1953
24c. NAME OF CEMETERY OR CREMATORY: Mounds Cemetery
24d. LOCATION (City, town, or county) (State): Mounds, Ill.

DATE REC'D BY LOCAL REG.: 10-3-53
REGISTRAR'S SIGNATURE: J. S. Schaumann 57-0
25. FUNERAL DIRECTOR'S SIGNATURE: Lloyd Russell — ADDRESS: Piggott, Ark.

(Licensed Embalmer's Statement on Reverse Side)

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

RECEIVED DUNKLIN COUNTY HEA

DEPARTMENT 10-12-57

COUNTY FILE NUMBER 1053-

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 me

Student Embalmer No.

working under my personal supervision.

Student
Student Embalmer

Signed Leroy J Tyler

Licensed Embalmer No. 1001 ark

P. O. Address Piggott Ar

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply w the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.