

FILED MAY 3 1954

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATHState File No. 11386  
Registrar's No. 114

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 47 PRIMARY REG. DIST. NO. 3008

1. PLACE OF DEATH a. COUNTY <b>CALLOWAY MISSOURI</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE: <b>MISSOURI</b> b. COUNTY <b>IACLEIDE</b>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>FULTON MISSOURI</b>		c. CITY OR TOWN <b>LEBANON</b>	d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. LENGTH OF STAY (in this place) <b>8 days</b>		e. STREET ADDRESS (If rural, give location) <b>532 south Adams</b>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>STATE HOSPITAL NO 1.</b>			

3. NAME OF DECEASED (Type or Print) a. (First) <b>HOWARD</b>	b. (Middle) <b>ALBERT</b>	c. (Last) <b>HAMILTON</b>	4. DATE OF DEATH (Month) (Day) (Year) <b>April-29 1954</b>
---	---------------------------	---------------------------	---

5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Married</b>	8. DATE OF BIRTH <b>January-20-1879</b>	9. AGE (In years last birthday) <b>75</b>	IF UNDER 1 YEAR Months <b>3</b> Days <b>10</b>	IF UNDER 24 HRS. Hours <b>10</b> Min.
--------------------	-------------------------------	---	---	---	--	---------------------------------------

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Physician &amp; Surgeon</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>Practicing Medicine</b>	11. BIRTHPLACE (City and State or Foreign Country) <b>Cleveland Ohio</b>	12. CITIZEN OF WHAT COUNTRY? <b>U. S. A</b>
--	--	--	---

13a. FATHER'S NAME <b>Albert J Hamilton</b>	13b. MOTHER'S MAIDEN NAME <b>Emma S Brooks</b>	14. NAME OF HUSBAND OR WIFE <b>Wife Lois N Casey Hamilton</b>
---	--	---

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <b>Not given</b>	16. SOCIAL SECURITY NO. <b>None Given</b>	17. INFORMANT'S SIGNATURE OR NAME <b>Hospital Records</b>	ADDRESS <b>Fulton Mo</b>
---	---	---	--------------------------

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, ashenia, etc. It means the disease, injury, or complication which caused death.	1. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Peritonitis, Perforated Duodenal Ulcer</b>		INTERVAL BETWEEN ONSET AND DEATH <b>24 Hrs.</b>
	ANTECEDENT CAUSES <b>A Contributing Factor.</b>		
	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	20. AUTOPSY? YES <input checked="" 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) m.	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 **Apr-20-54**, 19\_\_\_\_, to **Apr-29-54**, 19\_\_\_\_, that I last saw the deceased alive on **Apr-29**, 1954 and that death occurred at **3:45P** m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <b>Henry Fowler M. D.</b>	23b. ADDRESS <b>Fulton Mo</b>	23c. DATE SIGNED <b>4/29/54</b>
--	-------------------------------	---------------------------------

24a. BURIAL, CREMATION, TOMB REMOVAL (Specify) <b>Burial</b>	24b. DATE <b>May 2-1954</b>	24c. NAME OF CEMETERY OR CREMATORY <b>Lebanon Cem.</b>	24d. LOCATION (City, town, or county) (State) <b>Lebanon Mo</b>
--	-----------------------------	--	---

DATE REC'D BY LOCAL REG. <b>April 30-1954</b>	REGISTRAR'S SIGNATURE <b>Martha Lawrence</b>	25. FUNERAL DIRECTOR'S SIGNATURE <b>Wallace Funeral Home</b>	ADDRESS <b>Fulton Mo</b>
---	--	--	--------------------------

(Licensed Embalmer's Statement on Reverse Side)

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

NOV 21 1956

---

---

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 .....  
Signature of Student Embalmer

Signed *Wm. C. Browning* .....

Licensed Embalmer No. *7.7.2.*

P. O. Address *Fulton, N.Y.*

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.