

FILED FEB 24 1955

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **4830**  
Registrar's No. **463**

|   |  |   |  |   |  |  |  |
|---|--|---|--|---|--|--|--|
| BIRTH NO. _____   |  | REG. DIST. NO. <u>149</u>   |  | PRIMARY REG. DIST. NO. <u>1002</u>  |  | Registrar's No. <u>463</u>   |  |
| 1. PLACE OF DEATH<br>a. COUNTY <b>Jackson</b>   |  |   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).<br>a. STATE <b>Missouri</b> b. COUNTY <b>Jackson</b> |  |  |  |
| b. CITY (If outside corporate limits, write RURAL and give township)<br>OR TOWN <b>Kansas City</b>  |  | c. LENGTH OF STAY (in this place)<br><b>50 yrs.</b>   |  | c. CITY OR TOWN <b>Kansas City</b>  |  | d. Is Residence within limits of a city or incorporated town?<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |  |
| d. FULL NAME OF HOSPITAL OR INSTITUTION <b>St. Luke's Hospital</b>  |  |   |  | STREET ADDRESS (If rural, give location)<br><b>2160 S 4555 Main</b>   |  |  |  |
| 3. NAME OF DECEASED<br>(Type or Print) <b>GRACE</b>   |  | a. (First) <b>MAUDE</b>   |  | b. (Middle) <b>HAMILTON</b>   |  | c. (Last)  |  |
| 5. SEX <b>Female</b>  |  | 6. COLOR OR RACE <b>white</b>   |  | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>single</b>  |  | 4. DATE OF DEATH (Month) (Day) (Year)<br><b>Jan. 30 1955</b>   |  |
| 8. DATE OF BIRTH <b>June 29, 1887</b>   |  | 9. AGE (In years last birthday) <b>67</b>   |  | IF UNDER 1 YEAR<br>Months Days Hours Min  |  | IF UNDER 24 HRS.<br>Hours Min  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Clerk - Bruce Dodson Insurance Co.</b>  |  | 10b. KIND OF BUSINESS OR INDUSTRY   |  | 11. BIRTHPLACE (City and State or Foreign Country)<br><b>San Francisco, California</b>  |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  |
| 13a. FATHER'S NAME<br><b>Thomas J. Hamilton</b>   |  | 13b. MOTHER'S MAIDEN NAME<br><b>Susan Grace Kerr</b>  |  | 14. NAME OF HUSBAND OR WIFE<br><b>----</b>  |  |  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br><b>no</b>   |  | 16. SOCIAL SECURITY NO.<br><b>486-03-8993</b>   |  | 17. INFORMANT'S SIGNATURE OR NAME ADDRESS<br><b>Mrs. N. J. Flora 5325 Swope Parkway</b>   |  |  |  |
| 18. CAUSE OF DEATH<br>Enter only one cause per line for (a), (b), and (c)<br><br><i>*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.</i>                        |  | MEDICAL CERTIFICATION<br>I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Melano-sarcoma eye-metastasis</b><br><br>ANTECEDENT CAUSES<br>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.<br>DUE TO (b) _____<br>DUE TO (c) _____<br><br>II. OTHER SIGNIFICANT CONDITIONS<br>Conditions contributing to the death but not related to the disease or condition causing death.<br><br><b>1927</b> |  |   |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>2 yrs</b>   |  |
| 19a. DATE OF OPERATION  |  | 19b. MAJOR FINDINGS OF OPERATION  |  |   |  | 20. AUTOPSY?<br>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)   |  | 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 <u>Oct 13, 1954</u> , to <u>Jan 30, 1955</u> , that I last saw the deceased alive on <u>Jan 30, 1955</u> , and that death occurred at <u>7:30 P.m.</u> , from the causes and on the date stated above. |  |   |  |   |  |  |  |
| 23a. SIGNATURE <b>M. Donald McFarland</b> (Degree or title) <b>M.D.</b>   |  |   |  | 23b. ADDRESS <b>315 Nichols Rd. N.C.Mo</b>  |  | 23c. DATE SIGNED <b>Feb 1, 1955</b>  |  |
| 24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>   |  | 24b. DATE <b>2-1-55</b>   |  | 24c. NAME OF CEMETERY OR CREMATORY <b>Forest Hill</b>   |  | 24d. LOCATION (City, town, or county) (State)<br><b>Kansas City Missouri</b>   |  |
| DATE REC'D BY LOCAL REG. <b>2-1-55</b>  |  | REGISTRAR'S SIGNATURE <b>Neva Marshall</b>  |  | 25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS<br><b>STINE &amp; MCCLURE UNDERTAKING CO. K.C.MO.</b>  |  |  |  |

(Licensed Embalmer's Statement on Reverse Side)

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

Ohio Medical &  
215 Plaza Med. Bldg.  
Li 1533

Exp 11:09 P.M.

4th floor - outpat medical center  
10:30am - 10:45am center

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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 ....., Student Embalmer No. .... working under my personal supervision..

Student.....  
Signature of Student Embalmer

Signed *Elmer D. Tipton*.....

Licensed Embalmer No. *4817*.....

P. O. Address *Kansas City*.....

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.