

0.300
0.48

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **40205**

FILED DEC 19 1955

BIRTH NO. _____ REG. DIST. NO. **128** PRIMARY REG. DIST. NO. **2000** Registrar's No. **1119**

1. PLACE OF DEATH a. COUNTY Greene		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Greene	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Springfield		c. CITY OR TOWN Springfield,	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) 6 months		f. STREET ADDRESS (If rural, give location) 1633 S. Fremont	
d. FULL NAME OF HOSPITAL OR INSTITUTION 711 Cherry			

3. NAME OF DECEASED (Type or Print)	a. (First) Grace	b. (Middle) E.	c. (Last) Hamrick	4. DATE OF DEATH (Month) (Day) (Year) December 12, 1955
-------------------------------------	-------------------------	-----------------------	--------------------------	--

5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH November 13, 1876	9. AGE (In years last birthday) 79	IF UNDER 1 YEAR Months 0 Days 29	IF UNDER 1 HR. 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 In Home	11. BIRTHPLACE (City and State or Foreign Country) Clarence, Missouri	12. CITIZEN OF WHAT COUNTRY? USA
--	--	--	---

13a. FATHER'S NAME William Kemper	13b. MOTHER'S MAIDEN NAME Kate Irwin	14. NAME OF HUSBAND OR WIFE William L. Hamrick
--	---	---

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) 	16. SOCIAL SECURITY NO. Unknown	17. INFORMANT'S SIGNATURE OR NAME Mrs. W. A. Snodgrass	ADDRESS Springfield,
--	--	---	-----------------------------

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.	1. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Atherosclerosis, generalized		MO. _____ INTERVAL BETWEEN ONSET AND DEATH Sev. yrs
	ANTECEDENT CAUSES Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____		
	11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. 4500		

19a. DATE OF OPERATION _____	19b. MAJOR FINDINGS OF OPERATION _____	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" 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 **48**, 19**55**, to **12-12, 1955**, that I last saw the deceased alive on **12-10, 1955**, and that death occurred at **8 P.** m., from the causes and on the date stated above.

23a. SIGNATURE S. B. Lemmon	(Degree or title) MD	23b. ADDRESS Springfield	23c. DATE SIGNED 12-13-55
------------------------------------	-----------------------------	---------------------------------	----------------------------------

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE Dec. 15, 1955	24c. NAME OF CEMETERY OR CREMATORY Clarence	24d. LOCATION (City, town, or county) (State) Clarence, Missouri
---	--------------------------------	--	---

DATE REC'D BY LOCAL REG. 12-13-55	REGISTRAR'S SIGNATURE Edith Williamson	25. FUNERAL DIRECTOR'S SIGNATURE Borman - Schaff	ADDRESS Springfield, Mo.
--	---	---	---------------------------------

(Licensed Embalmer's Statement on Reverse Side)

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

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 *L. B. Smith*

Licensed Embalmer No. 317

P. O. Address *Springfield*

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.