

FILED SEP 12 1956

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

26410

STATE FILE NUMBER

Registration District No. 86 Primary Registration District No. 4149 Registrar's No. 23-1956

300  
1-56

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

1. PLACE OF DEATH a. COUNTY <u>Crawford.</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Butler.</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Cuba.</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>Broseley 0129</u> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>29 Home St A. P. O. Buildings</u>		Length of stay in lb <u>24 Days</u>	d. STREET ADDRESS (If outside, give location) <u>Rt. 1</u> Reside on Form Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Frank</u> Middle <u>Hamilton</u> Last <u>Day</u>			4. DATE OF DEATH Month <u>9</u> Day <u>5</u> Year <u>56</u>
5. SEX <u>Male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MAY 12 1879</u>
9. AGE (In years last birthday) Months <u>77</u> Days <u>3</u> Hours <u>27</u> Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Railroad (retired)</u>	
10b. KIND OF BUSINESS OR INDUSTRY <u>Frisco RR.</u>		11. BIRTHPLACE (City and state or country) <u>Fairfield Ill.</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>James Day</u>		14. MOTHER'S MAIDEN NAME <u>Sarah Borah.</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <u>NO None</u>		16. SOCIAL SECURITY NO. <u>702-03-8306</u>	17. INFORMANT Address <u>Marion Keith Day - Broseley Mo</u>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Virus Hepatitis</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) _____ DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH <u>6-7 mo</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(n) <u>092x</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY. Hour _____ a. m. _____ p. m. _____	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		
20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION	COUNTY	STATE
21. I attended the deceased from <u>July - 56</u> to <u>Sept 5 1956</u> and last saw <sup>her</sup> alive on <u>Sept 5 1956</u> Death occurred at <u>6:00 PM.</u> m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>F. B. Melius D.O.</u>		22b. ADDRESS <u>Cuba. Mo.</u>	22c. DATE SIGNED <u>9-6-56</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	23b. DATE <u>9-5-56</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Bloomfield Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>Bloomfield, Mo.</u>
24. FUNERAL DIRECTOR <u>F. B. Melius</u>		25. DATE RECD. BY LOCAL REG. <u>9-6-1956</u>	26. REGISTRAR'S SIGNATURE <u>F. B. Melius</u>

(Licensed Embalmer's Statement on Reverse Side)

SEP 13 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 *Paul A. Johnson*

Licensed Embalmer No. 347

P. O. Address Cuba

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.