

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

33120

STATE FILE NUMBER

FILED SEP 23 1957

Registration District No. 314 Primary Registration District No. 3059 Registrar's No. 296

1. PLACE OF DEATH a. COUNTY St. Francois			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY St. Francois		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Bonne Terre		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN Farmington		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Bonne Terre Hosp.			Length of stay in lb 3 WEEKS		
d. STREET ADDRESS 108 Potosi			(If outside, give location) 16 Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Fielding Middle Alonzo Last Hambrick			4. DATE OF DEATH Month Sept Day 15 Year 1957		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec 17 1874	9. AGE (In years) (approx. birthday) 82	IF UNDER 1 YEAR Month 8 Day 28 Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Minster		10b. KIND OF BUSINESS OR INDUSTRY Retired		11. BIRTHPLACE (City and state or country) Washington County Ill	
13. FATHER'S NAME James Alonzo Hambrick			12. CITIZEN OF WHAT COUNTRY? USA		
14. MOTHER'S MAIDEN NAME Liddie Dell Roberts			17. INFORMANT Address Minerva Jane Hambrick (wife)		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 500-16-7822		17. INFORMANT Address Minerva Jane Hambrick (wife)	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial infarction Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) arteriosclerotic heart disease DUE TO (c) 					INTERVAL BETWEEN ONSET AND DEATH 23 days 6 mo
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> 2
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 Month Day Year 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 Jan 1957 to 9-15-57 and last saw him him alive on 7-15-57 Death occurred at 9 AM m on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE C. E. Carleton M.D. (Degree or title)			22b. ADDRESS Farmington Mo		22c. DATE SIGNED 9-18-57
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE Sept 20 1957		23c. NAME OF CEMETERY OR CREMATORY Bonne Terre Cemetery	
		23d. LOCATION (City, town, or county) Bonne Terre, Mo.		(State)	
24. FUNERAL DIRECTOR BOYER-BENHAM ADDRESS Bonne Terre, Mo.			25. DATE RECD. BY LOCAL REG. Sept. 19, 1957		26. REGISTRAR'S SIGNATURE Ether Rudloff

(Licensed Embalmer's Statement on Reverse Side)

Health, Welfare, Public Service
0
300
1-56
All diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes.
USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes.

MEDICAL CERTIFICATION

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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 *S. T. Lyles*

Licensed Embalmer No. *36*

P. O. Address *Meriden*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (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.