

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

34881

STATE FILE NUMBER

FILED NOV 12 1957

Registration District No. 42 Primary Registration District No. 1000 Registrar's No. 1195

1. PLACE OF DEATH a. COUNTY <b>Buchanan</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Jackson</b>				
b. CITY (If outside corporate limits, give TOWNSHIP only) TOWN <b>St. Joseph</b>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>Kansas City</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>State Hosp. #2</b>		Length of stay in lb <b>1 yr. 11 mo. 22 da.</b>		d. STREET ADDRESS (If outside, give location) <b>unknown</b>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <b>Dorothy Mae Hamilton</b>				4. DATE OF DEATH <b>Nov. 2, 1957</b>				
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>August 14, 1913</b>	9. AGE (In years last birthday) <b>44</b>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>home</b>		11. BIRTHPLACE (City and state or country) <b>Kansas City, Kansas</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		
13. FATHER'S NAME <b>Walter H. Peters</b>				14. MOTHER'S MAIDEN NAME <b>Susan Toyne</b>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>unknown</b>		17. INFORMANT Address <b>State Hosp. #2 Record, St. Joseph, Mo.</b>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Multiple Cerebral Hemorrhages</b>						INTERVAL BETWEEN ONSET AND DEATH <b>2 mos.</b>		
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>Generalized arteriosclerosis</b>						DUE TO (c) <b>331XB</b>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Chronic brain Syndrome associated with syphilis of the central nervous system State Hosp. #2. Diagnosis 11/29/55</b>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> <b>2</b>		
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 <b>Nov. 2, 1957</b> to <b>Nov. 2, 1957</b> and last saw <b>her</b> alive on <b>Nov. 2, 1957</b> Death occurred at <b>7:45 p.</b> m on the date stated above; and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE (Degree or title) <b>H F Mundy M.D.</b>				22b. ADDRESS <b>St Joseph Mo Nov 2 1957</b>		22c. DATE SIGNED		
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>removal</b>		23b. DATE <b>11/3/1957</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Mount Washington</b>		23d. LOCATION (City, town, or county) (State) <b>Buried Nov 6-1957 Kansas City, Kansas</b>			
24. FUNERAL DIRECTOR ADDRESS <b>Heaton-Bowman St. Joseph, Mo.</b>				25. DATE RECD. BY LOCAL REG. <b>Nov 6, 1957</b>		26. REGISTRAR'S SIGNATURE <b>Mrs Robert Fulton</b>		

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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.....

*James B. Hawkins*

Licensed Embalmer No. 45

P. O. Address 319 So 10th St

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