

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

MAINTAIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

FILED NOV 13 1942

MISSOURI STATE BOARD OF HEALTH  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH

33790  
Do not use this space.

1. PLACE OF DEATH  
 (a) County Grundy Registration District No. 132 40  
 (b) Township \_\_\_\_\_ Primary Registration District No. 3021 1 Registered No. \_\_\_\_\_  
 (c) City Trenton (d) Street No. \_\_\_\_\_ St. \_\_\_\_\_  
 (If death occurred in Hospital or Institution, write its name instead of street and number)  
 (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME JOHN JACOB HAMILTON  
 (a) Residence, No. 307 E. 11<sup>th</sup> St. St.  (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE W.M. 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED 1 M  
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Ella Hamilton  
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Dec 12 1863  
 7. AGE YEARS MONTHS DAYS If LESS than 1 day, .....hra. or .....min.  
78 9 28  
 OCCUPATION  
 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.  
 9. Industry or business in which work was done, as saw mill, bank, etc. Retired Farmer  
 10. Date deceased last worked at this occupation (month and year) \_\_\_\_\_ 11. Total time (years) spent in this occupation \_\_\_\_\_  
 12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Ills. 1  
 FATHER  
 13. NAME Josephus Hamilton  
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Ohio 1  
 MOTHER  
 15. MAIDEN NAME Sarah Reese  
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Ohio 1  
 17. INFORMANT (ADDRESS) Fred Hamilton  
Kennett Mo  
 18. BURIAL, CREMATION, OR REMOVAL  
 PLACE Humphreys Mo DATE Oct 12 1942  
 19. FUNERAL DIRECTOR (NAME) (ADDRESS) W. R. Payne  
Call Mo  
 20. FILED 10-12 1942 Nala Hoffman  
1202 Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Oct 10 1942  
 22. I HEREBY CERTIFY, That I attended deceased from Oct 9 1942, to Oct 10 1942.  
 I last saw him alive on Oct 8 1942. Death is said to have occurred on the date stated above, at 8:25 A.M.  
 The principal cause of death and related causes of importance were as follows:  
Arterio Sclerosis  
 Date of onset unknown  
97  
 Other contributory causes of importance:  
 Name of operation \_\_\_\_\_ Date of \_\_\_\_\_  
 What test confirmed diagnosis? Phys. signs. Was there an autopsy? Yes  
 23. If death was due to external causes (violence), fill in also the following:  
 Accident, suicide, or homicide? \_\_\_\_\_ Date of injury \_\_\_\_\_, 1942.  
 Where did injury occur? \_\_\_\_\_ (Specify city or town, county, and State)  
 Specify whether injury occurred in industry, in home, or in public place.  
 Manner of injury \_\_\_\_\_  
 Nature of injury \_\_\_\_\_  
 24. Was disease or injury in any way related to occupation of deceased? No  
 If so, specify \_\_\_\_\_  
 (Signed) E. A. Duffly, M. D.  
 (Address) Trenton Mo.

---

---

**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.....  
....., Registered Apprentice No.....  
working under my personal supervision.

Signed.....

*RK Payne Jr*

Licensed Embalmer No.....

*3400*

P. O. Address.....

*Galt*

**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 this body is not embalmed, above space should be left blank.**