

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **18283**

FILED JUN 15 1948

Registration District No. _____

Primary Registration District No. **6076**

Registrar's No. **1260**

1. PLACE OF DEATH:

(a) County **St. Louis**
(b) City or town **Wash. Mo**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution **Robert Rod Hospital 0**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **28 days** (Specify whether
In this community **28 years** years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Mo** (b) County **St Louis**
(c) City or town **Wash. Mo** (If outside city or town limits, write "RURAL")
(d) Street No. **4204 Euclid** (If rural, give location)
(e) Citizen of foreign country? **-** (Yes or No)
If yes, name country _____

3: (a) PRINT FULL NAME

HAMILTON Fred

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **May** day **18**
year **1948** hour **9** minute **30 A.M.**

21. I hereby certify that I attended the deceased from **4-9-1948** to **5-18-1948**
that I last saw him alive on **5-17-1948** and that death occurred on the date and hour stated above.

Immediate cause of death

Chronic Pulmonary Tuberculosis

Duration

2

Quantity

132

Due to _____

Due to _____

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations _____

Of autopsy _____

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____
(b) Date of occurrence _____
(c) Where did injury occur? _____ (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work? _____ (Specify type of place) (e) Means of injury _____

23. Signature **John T. Coates M.D.** (M. D. or other)
Address **Robert Rod Hospital** Date signed **5/18/48**

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

MOTHER FATHER

11. Industry or business _____
12. Name **James Hamilton**
13. Birthplace **Washington** (City, town, or county) (State or foreign country)
14. Maiden name **Mary Jones**
15. Birthplace **Washington** (City, town, or county) (State or foreign country)
16. (a) Informant **Hospital Records**
(b) Address **Robert Rod Hospital Wash Mo**
17. (a) **Removal** (b) Date thereof **5-21-48** (Month) (Day) (Year)
(c) Place: burial or cremation **Hope, Ark.**

18. (a) Signature of funeral director **Charles J. Gates**
(b) Address **4107 Finney Avenue**
19. (a) **2-20-48** (Date received local registrar) (b) **Beulah Hopp** (Registrar's signature)

John J. Kalish M.D.

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.....

John K. Cuhningham....., Registered Apprentice No.....

working under my personal supervision.

Signed.....

John K. Cuhningham

.. Licensed Embalmer No. 4476.....

.P. O. Address 4107 Finney Avenue.....

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, fact should be so stated above.