

FILED DEC 30 1957

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

45876

STATE FILE NUMBER

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. **11828**

S. 300
v. 157

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
b. CITY (If outside corporate limits, give TOWNSHIP only) St. Louis		c. CITY OR TOWN Riverview Gardens	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION De Paul Hospital		d. STREET ADDRESS (If outside, give location) 9932 Jeffrey Drive	
3. NAME OF DECEASED (Type or print) First Harold Middle C Last Hamilton		4. DATE OF DEATH Month Dec Day 8 Year 1957	
5. SEX Male	6. COLOR OR RACE white	7. MARRIED OR NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan 2 1899
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Railroad Engineer		10b. KIND OF BUSINESS OR INDUSTRY Illinois Central RR	12. CITIZEN OF WHAT COUNTRY? USA
13a. FATHER'S NAME Charles A. Hamilton		13b. MOTHER'S MAIDEN NAME Nellie Morris	14. NAME OF HUSBAND OR WIFE Margaret D. Hamilton
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. 494-09-9668	17. INFORMANT Address Margaret D. Hamilton, 9932 Jeffrey Drive	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Lymphatic Leukemia			INTERVAL BETWEEN ONSET AND DEATH 2 Wks
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) _____ DUE TO (c) _____			204.0
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 checked="" 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 _____ 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 May 5, 1956 to Dec 8, 1957 and last saw him alive on 12/8/57 Death occurred at 9:35 AM m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <i>J. J. Gowan M.D.</i> (Doctor or title)		22b. ADDRESS 539 N. Grand St. St. Louis	22c. DATE SIGNED 12/9/57
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE Dec 11 1957	23c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery	23d. LOCATION (City, town, or county) (State) St. Louis Missouri
24. FUNERAL DIRECTOR ADDRESS Math Hermann & Son, Inc, 2161 E. Fair Av		25. DATE RECD. BY LOCAL REG. DEC 9 '57	26. REGISTRAR'S SIGNATURE <i>J. Carl Smith MD</i> MSB

MEDICAL CERTIFICATION
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 causally related.

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 *Allen C. Kay*

Licensed Embalmer No. *3737*
P. O. Address *St. Louis, Mo*

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.