

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

7924

1. PLACE OF DEATH

County Jackson Registration District No. 252 File No. 1105
 Township Raw City Registration District No. 1105 Registered No. 1105
 City K 6 Mo (No. of Elmer Hospital) St. Clifton Ward 1105

2. FULL NAME

Asst. B. Hammar
 (a) Residence. No. Clifton, Kansas Ward. 1105
 (Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. da. How long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Miss Hammar

6. DATE OF BIRTH (MONTH, DAY AND YEAR) June 1, 1885

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
39 9 13

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Carpenter
 (b) General nature of industry, business, or establishment in which employed (or employer)
 (c) Name of employer

9. BIRTHPLACE (CITY OR TOWN)

(STATE OR COUNTRY) Kansas

10. NAME OF FATHER Carl M. Hammar

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) Sweden

12. MAIDEN NAME OF MOTHER Dorah Johnson

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) Sweden

14. INFORMANT My Young Hammar
 (Address) Clifton, Kansas

15. FILED 3/14, 1925 M. M. Crove REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) March 14, 1925

17. I HEREBY CERTIFY, That I attended deceased from Feb. 1, 1925 to March 14, 1925 that I last saw h. live on March 12, 1925, and that death occurred, on the date stated above, at 9:10 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Brain abscess
following skull fracture
1925
1925 (duration) yrs. 4 mos. da.

CONTRIBUTORY (SECONDARY)

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH: Clay Center, Kans

19. DID AN OPERATION PRECEDE DEATH? Yes DATE OF March 8, 1925
 WAS THERE AN AUTOPSY? Yes

WHAT TEST CONFIRMED DIAGNOSIS? autopsy
 (Signed) F. Fisher M. D.

3-14, 1925 (Address) 822 Rich Bldg

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. (See reverse side for additional space.)

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Clifton, Kansas DATE OF BURIAL 3/16, 1925

20. UNDERTAKER R. V. Linder ADDRESS Clifton

Revised United States Standard Certificate of Death

(Approved by U. S. Census and American Public Health Association.)

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive Engineer, Civil Engineer, Stationary Fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*, (a) *Salesman*, (b) *Grocery*, (a) *Foreman* (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework* or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer, (retired 5 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report

"Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of———(name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasm); *Measles, Whooping cough, Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*), may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

NOTE.—Individual offices may add to above list of undesirable terms and refuse to accept certificates containing them. Thus the form in use in New York City states: "Certificates will be returned for additional information which give any of the following diseases, without explanation, as the sole cause of death: Abortion, cellulitis, childbirth, convulsions, hemorrhage, gangrene, gastritis, erysipelas, meningitis, miscarriage, necrosis, peritonitis, phlebitis, pyemia, septicemia, tetanus." But general adoption of the minimum list suggested will work vast improvement, and its scope can be extended at a later date.

ADDITIONAL SPACE FOR FURTHER STATEMENTS
BY PHYSICIAN.

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

1. PLACE OF DEATH

County Jackson Registration District No. _____ File No. _____
 Township Raw Primary Registration District No. _____ Registered No. 1103
 City H. C. Mo (No. St. Lukes Hosp) St. _____ Ward _____

2. FULL NAME Edel B. Hannar

(a) Residence No. _____ St. _____ Ward _____
 (Usual place of abode) (If nonresident give city or town and State)
 Length of residence in city or town where death occurred yrs. mos. da. How long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX _____ 4. COLOR OR RACE _____ 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) _____

16. DATE OF DEATH (MONTH, DAY AND YEAR) March 14 1925

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF _____

17. I HEREBY CERTIFY, That I attended deceased from _____, 19____, to _____, 19____ that I last saw h. _____ on _____, 19____, and that death occurred, on the _____ stated above, at _____ m.

6. DATE OF BIRTH (MONTH, DAY AND YEAR) _____

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Death abscess following skull fracture, caused by fall from school.

8. OCCUPATION OF DECEASED

- (a) Trade, profession, or particular kind of work _____
- (b) General nature of industry, business, or establishment in which employed (or employee) _____
- (c) Name of employer _____

CONTRIBUTORY (SECONDARY) 185
 (duration) _____ yrs. _____ mos. _____ da.

9. BIRTHPLACE (CITY OR TOWN) _____ (STATE OR COUNTRY) _____

18. WHERE WAS DISEASE CONTRACTED
 IF NOT AT PLACE OF DEATH: _____

10. NAME OF FATHER _____

DID AN OPERATION PRECEDE DEATH: _____ DATE OF _____

11. BIRTHPLACE OF FATHER (CITY OR TOWN) _____ (STATE OR COUNTRY) _____

WAS THERE AN AUTOPSY? _____

12. MAIDEN NAME OF MOTHER _____

WHAT TEST CONFIRMED DIAGNOSIS? _____

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) _____ (STATE OR COUNTRY) _____

(Signed) E. J. Hannar, M. D.
 , 19____ (Address) 822 Rice Bldg

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14. INFORMANT _____ (Address) _____

19. PLACE OF BURIAL, CREMATION, OR REMOVAL _____ DATE OF BURIAL _____

15. FILED 3/14/25 M. M. Crowe REGISTRAR

20. UNDERTAKER _____ ADDRESS _____

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

CAUSE OF DEATH in plain terms, so that it may be properly understood. REGISTERED SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE. \$1. DESCRIBED BY LAW.

SUPPLEMENTARY

Revised United States Standard Certificate of Death

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