

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

Do not use this space.

27064

1. PLACE OF DEATH

County Harrison
Township Fayette
City Fayette (No. _____)

Registration District No. 378
Primary Registration District No. 4222

File No. _____
Registered No. 37
St. _____ Ward _____

2. FULL NAME

Minnie B. Hammond
(a) Residence No. _____ St. _____ Ward _____
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. da. How long in U.S., if of foreign birth? yrs. mos. ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female | 4. COLOR OR RACE White | 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Single

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 7/12/1870

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
57 | 7 | 15

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work _____
(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) Massachusetts

PARENTS

10. NAME OF FATHER John Hammond

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

12. MAIDEN NAME OF MOTHER Esther B. Gray

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

14. INFORMANT (Address) Miss Kate Hammond Fayette, Mo.

15. FILED Dec. 5, 1927 W. C. Bonham REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Sept 27 1927

17. I HEREBY CERTIFY, That I attended deceased from April 20, 1927, to Sept. 27, 1927 that I last saw him alive on Sept. 26, 1927, and that death occurred, on the date stated above, at 6 A.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Adeno carcinoma of ovary.
459A

CONTRIBUTORY Renal metastasi (SECONDARY)

18. WHERE WAS DISEASE CONTRACTED 460 IF NOT AT PLACE OF DEATH _____

DID AN OPERATION PRECEDE DEATH? Yes DATE OF April 25, 1927

WAS THERE AN AUTOPSY? No

WHAT TEST CONFIRMED DIAGNOSIS? Microscopic section of mass.
(Signed) Wm. J. Shaw, M. D.
, 19 (Address) Fayette, Mo.

*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.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL City Cemetery DATE OF BURIAL 9/28/27

20. UNDERTAKER Guy T. Lacey ADDRESS Fayette

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.

1927

