

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

Do not use this space.

30361

1. PLACE OF DEATH

County.....**Jackson**..... Registration District No. 399
 Township.....**Kaw**..... Primary Registration District No. 1002
 City.....**Kansas City** (No. 2808)..... **Prospect** St. **II** Ward

File No.
 Registered No. 3883

2. FULL NAME

William F. Hammond
 (a) Residence. No. 2808 **Prospect** St. **II** 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

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 Mary M Hammond		
6. DATE OF BIRTH (MONTH, DAY AND YEAR) Feb. 3 1863		
7. AGE YEARS 64	MONTHS 8	DAYS 9
8. OCCUPATION OF DECEASED (a) Trade, profession, or particular kind of work..... Salesman (b) General nature of industry, business, or establishment in which employed (or employer)..... (c) Name of employer.....		
9. BIRTHPLACE (CITY OR TOWN) Des Moines (STATE OR COUNTRY) Iowa		
10. NAME OF FATHER Wm. Hammond		
11. BIRTHPLACE OF FATHER (CITY OR TOWN)..... (STATE OR COUNTRY) Not Known		
12. MAIDEN NAME OF MOTHER Not Known		
13. BIRTHPLACE OF MOTHER (CITY OR TOWN)..... (STATE OR COUNTRY) Not Known		

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) **Oct. 12 19 27**
 I HEREBY CERTIFY, That I attended deceased from July 19 1927, to Oct. 12, 1927, that I last saw him alive on Oct. 7, 1927, and that death occurred, on the date stated above, at 2:30 P. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Banner of esophagus
464
96 (duration) yrs. **8** mos. da.
 CONTRIBUTORY **Rupture aorta**
 (SECONDARY) (duration) yrs. mos. da.

18. WHERE WAS DISEASE CONTRACTED
 IF NOT AT PLACE OF DEATH.....
 Did an operation precede death? **No** DATE OF.....
 WAS THERE AN AUTOPSY? **no**
 WHAT TEST CONFIRMED DIAGNOSIS?
Greenlee (Signed)..... M.D.
10/3, 1927 (Address) **402 W. Main St. 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.

14. INFORMANT Mrs. Mary Hammond (Address) 2808 Prospect	19. PLACE OF BURIAL, CREMATION, OR REMOVAL Elmwood	DATE OF BURIAL Oct. 14 19 27
15. FILED <u>10/13, 27</u> M. M. Crowe REGISTRAR <i>user</i>	20. UNDERTAKER J. W. Wagner	ADDRESS I409 Grand Ave

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.

DEPARTMENT RECORD

Dr. A. R. Greenlee