

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

Do not use this space.

32048

**1. PLACE OF DEATH**

County.....  
Township.....  
City St. Louis

Registration District No. 791  
1003  
Primary Registration District No. ....  
No. 6749 Mitchel

File No. ....  
Registered No. 9420  
St. .... Ward)

**2. FULL NAME** Hanna W. Hammer

(a) Residence. No. 6749 Mitchel St. 4 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. da. (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) Widowed

5A. If MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Jensen Hammer

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Aug. 28, 1835

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, _____ hrs. or _____ min.
	92	1	23	

**8. OCCUPATION OF DECEASED**

(a) Trade, profession, or particular kind of work At Home  
(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) Germany

10. NAME OF FATHER Unknown

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

12. MAIDEN NAME OF MOTHER Unknown

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

14. INFORMANT Sophie Hammer  
(Address) 2701 Lucas Ave.

15. FILED OCT 23 1927 Max B. Starkeoff  
19..... Registrar

**MEDICAL CERTIFICATE OF DEATH**

2  
16. DATE OF DEATH (MONTH, DAY AND YEAR) Oct 21 1927

17. I HEREBY CERTIFY, That I attended deceased from May 1st, 1927, to Oct 21, 1927, that I last saw her alive on Oct 21, 1927, and that death occurred, on the date stated above, at 2:25 p.m.

**THE CAUSE OF DEATH WAS AS FOLLOWS:**

Nephritis (chronic)  
131  
1627290  
CONTRIBUTORY (SECONDARY) Age  
(duration) 93 yrs. mos. da.

18. WHERE WAS DISEASE CONTRACTED  
IF NOT AT PLACE OF DEATH..... South - Kansas

0 DID AN OPERATION PRECEDE DEATH? No. DATE OF.....

WAS THERE AN AUTOPSY? No.

WHAT TEST CONFIRMED DIAGNOSIS?.....  
(Signed) Geo. W. Harrison, M. D.

1927 (Address) 3532 Washington St

\*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 DATE OF BURIAL

New Pickens Cemetery Oct 24 1927

20. UNDERTAKER ADDRESS

Wm. P. Wells 2701 9th Street

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

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.

