

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

Do not use this space.
20684
20702
File No. _____
Registered No. **5473**
St. _____ Ward _____

1. PLACE OF DEATH

County _____ Registration District No. **791**
Township _____ Primary Registration District No. **1003**
City **St. Louis Mo** (No. **City Infirmary**)

2. FULL NAME

Mary Hammersmith

(a) Residence. No. **154 Russell Ave 13** Ward _____
(Usual place of abode)

Length of residence in city or town where death occurred _____ yrs. _____ mos. _____ ds. 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 w	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) Unknown				
7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, _____ hrs. or _____ min.
abt 53				
8. OCCUPATION OF DECEASED (a) Trade, profession, or particular kind of work housework. (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) **Mo**

PARENTS	10. NAME OF FATHER Reinold Hammersmith
	11. BIRTHPLACE OF FATHER (CITY OR TOWN) _____ (STATE OR COUNTRY) Germany
	12. MAIDEN NAME OF MOTHER ? Unknown
	13. BIRTHPLACE OF MOTHER (CITY OR TOWN) _____ (STATE OR COUNTRY) Unknown

14. INFORMANT **M. E. Parker**
(Address) **5850 Union St**

15. FILED **5 1930** **May E Parker** REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) **6-2-1930**

17. I HEREBY CERTIFY, That I attended deceased from **5-22-** 19**30**, to **6-2-** 19**30**, that I last saw her alive on **6-2-** 19**30**, and that death occurred, on the date stated above, at **4:55 P.m.**

THE CAUSE OF DEATH* WAS AS FOLLOWS:

cerebral hemorrhage

CONTRIBUTORY (SECONDARY) **7401** (duration) _____ yrs. _____ mos. _____ ds.

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

8 DID AN OPERATION PRECEDE DEATH? _____ DATE OF _____

WAS THERE AN AUTOPSY? _____

WHAT TEST CONFIRMED DIAGNOSIS?
(Signed) **W. K. Hubbell** M. D.
6-3-1930 (Address) **5600 avenue**

*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 **St Paul Church yard** DATE OF BURIAL **6-5-1930**

20. UNDERTAKER **Southern** ADDRESS **6320 8 Grand Blv**

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.

