

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

Do not use this space.

38975

1. PLACE OF DEATH
 County St. Louis Registration District No. 1035
 Township Poplar Primary Registration District No. 5372
 City _____ (No. _____) St. _____ (Ward _____)

2. FULL NAME John D. Hammond
 (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. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male **4. COLOR OR RACE** White **5. SINGLE, MARRIED, WIDOWED OR DIVORCED** Single
 (write the word)
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Single

6. DATE OF BIRTH (MONTH, DAY AND YEAR)
7. AGE YEARS MONTHS DAYS IF LESS than 1 day, _____ hrs. or _____ min.
63

8. OCCUPATION OF DECEASED
 (a) Trade, profession, or particular kind of work Farmer
 (b) General nature of industry, business, or establishment in which employed (or employer) _____
 (c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN) Dear Co Mo.
 (STATE OR COUNTRY)

10. NAME OF FATHER Herman Durman
11. BIRTHPLACE OF FATHER (CITY OR TOWN) West Falsan Germany
 (STATE OR COUNTRY)
12. MAIDEN NAME OF MOTHER Catherine Baese
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) on the King Germany
 (STATE OR COUNTRY)

14. INFORMANT Mrs. Anna Swardell
 (Address) St. Louis

15. FILED 12/23 1930 J. A. Kiscock
 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Dec 22 1930
17. I HEREBY CERTIFY, That I attended deceased from June 15 1930 to Dec 22 1930, that I last saw him alive on Nov 8 1930, and that death occurred, on the date stated above, at 6 30 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Cardiac Decomposition,
95 R
130 (duration) yrs. 6 mos. ds.
 CONTRIBUTORY Subacute Nephritis,
 (SECONDARY) (duration) 1 yrs. mos. ds.

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? usage physical
 (Signed) Geo. H. Mellett, M. D.
 . 19 _____ (Address) Salina 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 Family Graveyard **DATE OF BURIAL** 2/24 1930

20. UNDERTAKER H. D. Hobson **ADDRESS** Salina Mo.

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.

JAN 19 1931

