

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

Do not use this space.

1530

1. PLACE OF DEATH

County Jackson Registration District No. _____
 Township Kaw Primary Registration District No. 2912
 City Kansas City (No. 611 Forest) St. _____ Ward _____

File No. _____
 Registered No. 502
 St. _____ Ward _____

2. FULL NAME

Isaac Hammer
 (a) Residence. No. 611 Forest St. 1 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 Jewish 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) married

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 1865 - Jan 15

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
65 65 0 10 _____

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

9. BIRTHPLACE (CITY OR TOWN) Poland
 (STATE OR COUNTRY) _____

10. NAME OF FATHER John Hammer

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

12. MAIDEN NAME OF MOTHER. Fannie

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

14. INFORMANT Kettile Hammer
 (Address) 611 Forest

15. FILED 1 31 M. M. Orme REGISTER

MEDICAL CERTIFICATE OF DEATH

3
 16. DATE OF DEATH (MONTH, DAY AND YEAR) Jan 25 1931

17. I HEREBY CERTIFY, That I attended deceased from Dec 1 1930 to Jan 25 1931 that I last saw him... alive on Jan 24 1931, and that death occurred, on the date stated above, at 6 a m.

THE CAUSE OF DEATH WAS AS FOLLOWS:
Cerebral apoplexy
82A Hemiplegia
82D or least exhaustion
 (duration) yrs. 2 mos. ds.

CONTRIBUTOR (SECONDARY) J. J. W.
 (duration) yrs. mos. ds.

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

19. DID AN OPERATION PRECEDE DEATH? no DATE OF _____
 WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS? Symptoms
 (Signed) H. J. Gerovick M. D.
1/23, 19 (Address) 275 Angelle 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.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Blue Ridge Cem. DATE OF BURIAL 1-25-1931

20. UNDERTAKER Ligerman & Sons ADDRESS City 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.

Dr. J. J. J. J.

801 E. Broadway

Providence R.I.