

SEP 16 1938

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

29742  
Do not use this space.

PLACE OF DEATH

a) County Wike Registration District No. 686  
 b) Township 1 Primary Registration District No. 4410 Registered No. 10  
 c) City Carroll (d) Street No. \_\_\_\_\_  
 (If death occurred in Hospital or Institution, write its name instead of street and number) St. \_\_\_\_\_  
 (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U.S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME William Hammit  
 (a) Residence, No. \_\_\_\_\_ St.  (If nonresident, give city or town and State)  
 (Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX 7 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Widowed

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Aug 13 1938

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF See Hammit

22. I HEREBY CERTIFY, That I attended deceased from 8-1, 1938, to 8-13, 1938

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) April 17 1909

I last saw him alive on \_\_\_\_\_, 1938. Death is said to have occurred on the date stated above, at \_\_\_\_\_ m.

7. AGE YEARS MONTHS DAYS If LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min. 29 3 26

The principal cause of death and related causes of importance were as follows:

OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. \_\_\_\_\_  
 9. Industry or business in which work was done, as saw mill, bank, etc. \_\_\_\_\_  
 10. Date deceased last worked at this occupation (month and year) \_\_\_\_\_ 11. Total time (years) spent in this occupation \_\_\_\_\_

Cancer of rectum Date of onset \_\_\_\_\_

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Ills

Other contributory causes of importance: HbN

FATHER 13. NAME Simpson

Name of operation Noxer Date of \_\_\_\_\_  
 What test confirmed diagnosis? \_\_\_\_\_ Was there an autopsy? No

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Ills

MOTHER 15. MAIDEN NAME Ho not / mms

23. If death was due to external causes (violence), fill in also the following:  
 Accident, suicide, or homicide? \_\_\_\_\_ Date of injury \_\_\_\_\_ 19\_\_\_\_  
 Where did injury occur? \_\_\_\_\_ (Specify city or town, county, and State)  
 Specify whether injury occurred in industry, in home, or in public place. \_\_\_\_\_

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) \_\_\_\_\_

17. INFORMANT (ADDRESS) Mrs H Eison  
Carroll Mo

Manner of injury \_\_\_\_\_  
 Nature of injury \_\_\_\_\_

18. BURIAL, CREMATION, OR REMOVAL PLACE Carroll Mo DATE Aug 14 38

19. FUNERAL DIRECTOR (NAME) (ADDRESS) W J Kates  
Windsor Mo

24. Was disease or injury in any way related to occupation of deceased? \_\_\_\_\_  
 If so, specify \_\_\_\_\_  
 (Signed) T H Wilson M. D.  
 (Address) Bowling Green Mo

20. FILED 7-14 Gene Hendrix Local Registrar

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is

HEALTH BOARD OF DISTRICT OF COLUMBIA  
DISTRICT OF COLUMBIA  
HEALTH BOARD OF DISTRICT OF COLUMBIA

RECEIVED

District Health Officer No. 10

District File Number 10-38-32

Date Filed 9/14/38

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,

or by

Registered Apprentice No. \_\_\_\_\_, working under my personal supervision.

Signed

*Wm Blutes*

Licensed Embalmer No. 3331

P.O. Address

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.

FILL IN ANSWERS TO ALL SPACES  
CHECKED IN RED PENCIL.

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

29747  
Do not use this space.

1. PLACE OF DEATH

(a) County Polk Registration District No. 686  
(b) Township..... Primary Registration District No. 440 Registered No.....  
(c) City Curryville (d) Street No..... St. ....  
(If death occurred in Hospital or Institution, write its name instead of street and number)  
(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U.S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME Lillian HAMMETT

(a) Residence, No. .... St.  (If nonresident, give city or town and State)  
(Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (with the word) wid

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

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

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.  
79 3 26

OCCUPATION  
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.  
9. Industry or business in which work was done, as saw mill, bank, etc.  
10. Date deceased last worked at this occupation (month and year)  
11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

FATHER  
13. NAME

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

MOTHER  
15. MAIDEN NAME

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

17. INFORMANT (ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL

PLACE DATE, 19..

19. FUNERAL DIRECTOR (ADDRESS)

20. FILED Aug 14 1938 Gene E Hendrix Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Aug 13, 19 38

22. I HEREBY CERTIFY, That I attended deceased from .., 19... to .., 19...

I last saw h... alive on .., 19... Death is said to have occurred on the date stated above, at .. m. The principal cause of death and related causes of importance were as follows:

Date of onset

Other contributory causes of importance:

Name of operation Date of

What test confirmed diagnosis? Was there an autopsy?

23. If death was due to external causes (violence), fill in also the following: Accident, suicide, or homicide? Date of injury .., 19...

Where did injury occur? (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place.

Manner of injury

Nature of injury

24. Was disease or injury in any way related to occupation of deceased?

If so, specify (Signed) T. Z. Wilcoxon, M. D.

(Address) Bowling Green

SUPPLEMENTARY

REGISTRATION FEE NOT RECEIVED A FEE WILL BE CHARGED IF THIS STATEMENT OF OCCUPATION IS VERY IMPORTANT. CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.

S-29742