

CT 31 1938 RECD NOV 4 1938

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

36838
Do not use this space.

1. PLACE OF DEATH
 (a) County St Louis Registration District No. 784
 (b) Township _____ Primary Registration District No. 111 Registered No. 1779
 (c) City Beach Hgts. (d) Street No. St Mary's Hospital 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 Emma Hammond
 (a) Residence, No. Caseyville Township St. Caseyville, Ills.
 (Usual place of abode, if no street address, write county or city) (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) Single

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) July 5-1893

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
45 3 25

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Housework
 9. Industry or business in which work was done, as saw mill, bank, etc. at home
 10. Date deceased last worked at this occupation (month and year) October 10/38 11. Total time (years) spent in this occupation 25

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Caseyville Twsp / Ills.

FATHER
 13. NAME Fred Hammond
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) St Louis Mo.

MOTHER
 15. MAIDEN NAME Margaret Gebhardt
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) St. Louis Mo.

17. INFORMANT (ADDRESS) Mr. W. Gebhardt East St. Louis, Ills.
 18. BURIAL, CREMATION, OR REMOVAL PLACE Caseyville Ill DATE Nov 1/38
 19. FUNERAL DIRECTOR (ADDRESS) Tom Schaeffer Collinsville, Ills.
 20. FILED OCT 31 1938 D. M. M. D. D. D. Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Oct 30/38 1938

22. I HEREBY CERTIFY, That I attended deceased from 10-24-38, 1938, to 10-30, 1938.
 I last saw her alive on 10-30, 1938. Death is said to have occurred on the date stated above, at 12:30A.m.
 The principal cause of death and related causes of importance were as follows:
Complete hepatic failure following biliary obstruction
 Date of onset _____
 Other contributory causes of importance: _____
Cholecystocholedochostomy
 Name of operation Post. gall. intestinal Date of 10-27-38
 What test confirmed diagnosis? Bile test Was there an autopsy? No.

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) D. M. M. D. D. D. M. D.
 (Address) St. Mary's Hospital

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.

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STATEMENT BY LICENSED EMBALMER

I, Geo. M. Schroepfel, Licensed Embalmer No. 1598

hereby certify that the body recorded on the reverse side of this certificate was embalmed by ME

L. E.

No. _____ or by _____, Registered Apprentice No. _____
working under my personal supervision.

Signed

Geo M Schroepfel

Licensed Embalmer No. 1598

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.)

FILL IN ANSWERS TO ALL SPACES
CHECKED IN RED PENCIL.

MISSOURI STATE BOARD OF HEALTH
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36838
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1. PLACE OF DEATH

(a) County St. Louis Registration District No. 784
 (b) Township _____ Primary Registration District No. 11 Registered No. _____
 (c) City Rick Hts (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 Emma Hammond

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

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.
45 3 25

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

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

MOTHER 15. MAIDEN NAME

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

17. INFORMANT (ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL

PLACE DATE

19. FUNERAL DIRECTOR (ADDRESS)

20. FILED _____, 19 _____

Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Oct 30, 1938

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

I last saw him _____ 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:

Complete Hepatic failure following Biliary obstruction with bladder disease & common duct obstruction due to stones & structure
 Other contributory causes of importance:

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 Name of operation Cholecystoenterostomy Day of _____
 What test confirmed diagnosis? Post-operative 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) M. K. Purcell, M. D.
 (Address) St. Marys Hosp

SUPPLEMENT

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. REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.

