FILED AUG 9 1940

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 24663

Registration District No. 85 Primary Registration District No. 1001 Registrar's No. 788

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:

(a) County Buchanan

(b) City or town St. Joseph (If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: St. Joseph's Hospital (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 2 days (Specify whether

In this community 74 years. years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Buchanan

(c) City or town St. Joseph (If outside city or town limits write "RURAL")

(d) Street No. 1221 N. 11th St. (If rural, give location)

(e) If foreign born, how long in U. S. A.? ____ years.

3. (a) PRINT FULL NAME Frederick Julius Hamaker 526

3. (b) If veteran, name war None

3. (c) Social Security No. None

4. Sex Male

5. Color or race White

6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Lillian Hamaker

6. (c) Age of husband or wife if alive 66 years

7. Birth date of deceased April (Month) 28 (Day) 1866 (Year)

8. AGE: Years 74 Months 2 Days 23 If less than one day ____ hr. ____ min.

9. Birthplace St. Joseph, (City, town, or county) Missouri (State or foreign country)

10. Usual occupation Retired Chief Clerk

11. Industry or business Rock Island R.R.

FATHER
12. Name Samuel T. Hamaker
13. Birthplace Quincy (City, town, or county) Illinois (State or foreign country)

MOTHER
14. Maiden name Clarisa Haymaker
15. Birthplace Unknown (City, town, or county) Unknown (State or foreign country)

16. (a) Informant Thomson R. Hamaker

(b) Address St. Joseph, Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof July 24, 1940 (Month) (Day) (Year)

(c) Place: burial or cremation Mt. Auburn Cemetery

18. (a) Signature of funeral director H. O. Sidenfaden & Son

(b) Address 1802 Union Str. St. Joseph, Mo.

19. (a) 7-22-1940 (Date received local registrar) (b) H. J. Nettlebush (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 21st year 1940 hour 6 minute 15 A.M.

21. I hereby certify that I attended the deceased from July 20, 1940 to July 21, 1940 that I last saw him alive on July 21, 1940 and that death occurred on the date and hour stated above.

Immediate cause of death Obstruction of bowel

Due to Malignant tumor

Due to

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations

Of autopsy None

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify)

(b) Date of occurrence

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? (Specify type of place)

While at work? (e) Means of injury

85

23. Signature Collie Kennedy (M. D. or other)

Address Kirkpatrick Bldg Date signed 7-21-40

(Licensed Embalmer's Statement on Reverse Side)

46

NOV 9 1934

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 Albert P. Harrington

Licensed Embalmer No. 3258

P. O. Address St. Joseph, Mo.

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

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

No. 2B
2-21-40
L 122559

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1. PLACE OF DEATH:

(a) County: Buchanan

(b) City or town: St Joseph
(If outside city or town limits, write "Rural" and name of township)

(c) Name of hospital or institution:

(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution (Specify whether years, months or days)

In this community

2. USUAL RESIDENCE OF DECEASED:

(a) State (b) County

(c) City or town
(If outside city or town limits write "RURAL")

(d) Street No.
(If rural, give location)

(e) If foreign born, how long in U. S. A.? years.

3. (a) PRINT FULL NAME: Frederick Julius Hamaker

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex: M

5. Color or race: W

6. (a) Single, widowed, married, divorced: M

6. (b) Name of husband or wife

6. (c) Age of husband, or wife, if alive years

7. Birth date of deceased (Month) (Day) (Year)

8. AGE: Years 74 Months 2 Days 23 If less than one day hr. min.

9. Birthplace (City, town, or county) (State or foreign country)

10. Usual occupation

11. Industry or business

FATHER 12. Name

13. Birthplace (City, town, or county) (State or foreign country)

MOTHER 14. Maiden name

15. Birthplace (City, town, or county) (State or foreign country)

16. (a) Informant

(b) Address

17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)

(c) Place: burial or cremation

18. (a) Signature of funeral director

(b) Address

19. (a) 9-6-40 (Date received local registrar) (b) H. J. Nestlebush (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 21 year 1940 hour minute M.

21. I hereby certify that I attended the deceased from , 19, to , 19; that I last saw him alive on , 19; and that death occurred on the date and hour stated above.

Immediate cause of death — Duration

Obstruction of Bowel

Due to Malignant Tumor

Due to Duodenum

Other conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify)

(b) Date of occurrence

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?

While at work? (Specify type of place) (e) Means of injury

23. Signature Gallis Roundy (M. D. or other)

Address St Joseph Mo Date signed Sept 6 1940

SUPPLEMENTARY