

No. 2
4-13-40
7-17-39
I X23159

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

38542

State File No. _____

DEC 5 - 1940
District No. 213

Primary Registration District No. 3014

Registrar's No. 284

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

1. PLACE OF DEATH: Cole
(a) County _____
(b) City or town Jefferson City, Mo.
(c) Name of hospital or institution: 412 Lafayette Home
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether)
In this community yes years, months or days _____

3. (a) PRINT FULL NAME Robert M. Hammons
3. (b) If veteran, name war _____ 3. (c) Social Security No. 2

4. Sex Male 5. Color or race negro 6. (a) Single, widowed, married married
6. (b) Name of husband or wife Emma Allen Hammons 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased Jan 10 1870
(Month) (Day) (Year)

8. AGE: Years 70 Months 10 Days 17 If less than one day _____ hr. _____ min.

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

10. Usual occupation Laborer

11. Industry or business _____

12. Name unknown 9
13. Birthplace unknown (City, town, or county) (State or foreign country)

14. Maiden name unknown 9
15. Birthplace unknown (City, town, or county) (State or foreign country)

16. (a) Informant Emma Allen Hammons

(b) Address 409 Lafayette

17. (a) Longview (b) Date thereof 10-30-40
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Longview

18. (a) Signature of funeral director Lumber Service
(b) Address 700 Jefferson St

19. (a) 11-4-40 (b) D. B. [Signature]
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Cole
(c) City or town Jefferson City
(If outside city or town limits, write "RURAL")
(d) Street No. Lafayette St
(If rural, give location)
(e) If foreign born, how long in U. S. A. ? _____ years.

MEDICAL CERTIFICATION
20. DATE OF DEATH, Month Oct day 27 year 1940 hour _____ minute 0 M.

21. I hereby certify that I attended the deceased from November 1939 to 10/27/40, 1940 that I last saw him alive on 10/27/40, 1940 and that death occurred on the date and hour stated above.

Immediate cause of death Arctic Regurgitation

Due to _____

Due to _____

Other conditions Senility
(Include pregnancy within 3 months of death)

Major findings: _____
Of operations _____

Of autopsy _____

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 D. B. [Signature] (M. D. certificate) _____
Address Jefferson City Date signed 11/4/40

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

APR 4 1946

APR 4 1946

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.....

J. H. Anderson

Licensed Embalmer No.....

3641

P. O. Address.....

Jefferson City

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, fact should be so stated above.