

FILED APR 28 1941

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

11670

State File No. _____

Registration District No. 678

Primary Registration District No. 4404

Registrar's No. _____

1. PLACE OF DEATH

(a) County Phelps
(b) City or town St. James
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 1
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether _____)
In this community _____ years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Phelps
(c) City or town St. James
(If outside city or town limit, write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) If foreign born, how long in U. S. A.? 0 years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 3 day 16
year 1941 hour 11 00 minute a 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: Acute Indigestion

Due to N.M.D.

Due to _____

Other conditions (Include pregnancy within 3 months of death) 11 1/2

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 P. B. Hall (M. D. or other) Coroner
Address Rolla Mo Date signed 3-17-41

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

3. (a) PRINT FULL NAME Ernest Hammer

3. (b) If veteran, name war _____ 3. (c) Social Security No. 457-05-0193

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced ✓

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 about 58 Months _____ Days _____ If less than one day _____ hr. _____ min.

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

10. Usual occupation Laborer

11. Industry or business _____

12. Name Dora Kover

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

14. Maiden name Dora Kover

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

16. (a) Informant H. J. Delano

(b) Address St James Mo

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

(c) Place: burial or cremation City Cem

18. (a) Signature of funeral director H. J. Delano

(b) Address St James Mo

19. (a) 4/1/41 (Date received local registrar) (b) Elmer B. Dook (Registrar's signature)

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

MOTHER FATHER

RECEIVED

District Health Officer No. 5,

District File Number 441447

Date Filed

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.....

Licensed Embalmer No.....

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.

NEW YORK STATE DEPARTMENT OF HEALTH

No. 2
-4-41
17-39
X28390

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 11670

Registration District No. 678

Primary Registration District No. 4404

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Phelps
(b) City or town St James
(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
In this community _____ years, months or days)

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) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME

Fred Hammer

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 married

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 Months Days If less than one day
58 hr. min.

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

10. Usual occupation

11. Industry or business

12. Name

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

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. Signature of funeral director

(b) Address

19. (a) 6-9-41 (b) Elmer B. Houk
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 3 day 16
year 1941 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 _____

Due to _____

Due to _____

Other conditions (include pregnancy within 3 months of death)

Major findings: Of operations _____

Of autopsy _____

Duration

PHYSICIAN

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

(b) Date of occurrence _____

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

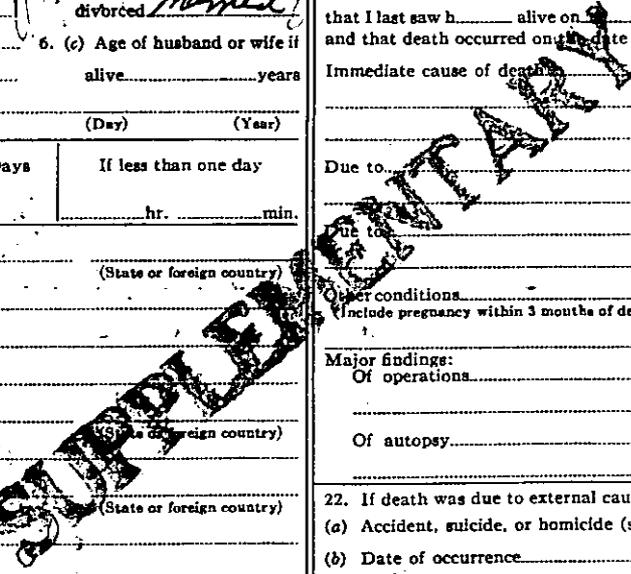
(d) Did injury occur in or about home, on farm, in industrial place, in public place?

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

23. Signature R. S. Null (M. D. or other)

Address Rolla Date signed _____

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



11676

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.....

Licensed Embalmer No.....

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, fact should be so stated above.