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X28390

FILLED NOV 24 1941

Registration District No. _____
Primary Registration District No. **1003**

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

1. PLACE OF DEATH:

(a) County _____

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

(c) Name of hospital or institution:
Josephine Heitkamp Hospital
(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 _____
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **000**
19

(c) City or town **St. Louis.** *24* **9**
(If outside city or town limits, write "RURAL") *0*

(d) Street No. **939 Utah Str.**
(If rural, give location)

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

3. (a) PRINT FULL NAME **Everett P. Gammon**

3. (b) If veteran, name war _____

3. (c) Social Security No. **489-03-6596**

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Oct** day **5** *6*
year **1941** hour **4** minute **40** A. M.

21. I hereby certify that I attended the deceased from **Oct 3**
19 **41** to **Oct 6** 19 **41**
that I last saw him alive on **Oct 6** 19 **41**
and that death occurred on the date and hour stated above.

4. Sex **Male** *O* 5. Color or race **Wht.**

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

6. (b) Name of husband or wife **Sophie A Gammon**

6. (c) Age of husband or wife if alive **34** years

7. Birth date of deceased **Sept.** **4** **1904**
(Month) (Day) (Year)

Immediate cause of death
General Peritonitis *2 days*

Due to **Acute Appendicitis Perforated** *3 days*

Due to _____

Other conditions (include pregnancy within 3 months of death) _____

8. AGE: Years **37** Months **1** Days **2** If less than one day _____
hr. _____ min. _____

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

10. Usual occupation **Policeman**

11. Industry or business **City Park Dept.**

12. Name **John G. Gammon**

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

14. Maiden name **Mary Sorensen**

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

16. (a) Informant **Sophie A. Gammon**

(b) Address **939 Utah Str.**

17. (a) **Burial** (b) Date thereof **10/9/41**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **New S. S. Peter & Paul**

18. (a) Signature of funeral director *W. E. Magdell*

(b) Address **1926 Allen Ave.**

19. (a) **OCT 8 1941** (b) _____
(Date received local registrar) (Registrar's signature)

Major findings: Of operations **Suppurative Appendicitis Peritonitis**

Of autopsy **None**

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 *John P. Hayward MD* **0**
Address **St. Louis** Date signed **10/7/41**

STATEMENT BY LICENSED EMBALMER

REG-111

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 Benj. C. Duncan
Licensed Embalmer No. 2272
P. O. Address 1926 All

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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 33024

Registration District No. 791

Primary Registration District No. 1003

Registrar's No. _____

1. PLACE OF DEATH:

- (a) County St Louis
- (b) City or town St Louis
(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)

3. (a) PRINT FULL NAME Everett J. Lammon

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 Sept 4 1904
(Month) (Day) (Year)

8. AGE: Years 37 Months _____ Days _____ (If less than one day _____ 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) _____ (b) Date thereof _____ (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) DEC 4 1941 (b) J F Bredeck
(Data received local Registrar) (Registrar's signature)

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 _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct Day 12 year 1941 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____; that I last saw him _____, 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 _____

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 _____ (M. D. or other) _____

Address _____ Date signed _____

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

SUPPLEMENTARY

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

1941
S-33094