

0. 2  
4-41  
17-39  
X26390

DEC 22 1941

399

State File No. \_\_\_\_\_

Registration District No. \_\_\_\_\_

Primary Registration District No. 1002

Registrar's No. 4194

1. PLACE OF DEATH:

(a) County Jackson,  
(b) City or town Kansas City,  
(c) Name of hospital or institution:  
3516 Paseo,  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution X  
(Specify whether  
In this community 70 years,  
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) Country Jackson City  
(c) City or town Kansas City  
(If outside city or town limits, write "RURAL")  
(d) Street No. 3516 Paseo  
(If rural, give location) 0  
(e) Citizen of foreign country? X (Yes or No)  
If yes, name country X

3. (a) PRINT FULL NAME Edward Clark Hamill,

3. (b) If veteran, name war no. 3. (c) Social Security No. 496-07-5995

4. Sex Male 0 5. Color or race White 6. (a) Single, widowed, married, divorced Married,

6. (b) Name of husband or wife Rua E. Hamill, 6. (c) Age of husband or wife if alive 72 years

7. Birth date of deceased October 8 1866  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
75 1 3 hr. min.

9. Birthplace Kansas, 1  
(City, town, or county) (State or foreign country)

10. Usual occupation Salesman,

11. Industry or business Wholesale Drugs,

MOTHER FATHER

12. Name John Smith Hamill,

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

14. Maiden name Jennie McClellan,

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

16. (a) Informant Mrs. Rua E. Hamill,

(b) Address 3516 Paseo, Kansas City, Mo.

17. (a) Burial, (b) Date thereof 11-12-41  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Forest Hill Cemetery,

18. (a) Signature of funeral director Stine & McClure,

(b) Address 3235 Gillham Plaza, K. C., Mo.

19. (a) 11-12-41 (b) M. M. Crow  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov 11<sup>th</sup> 41  
year 41 hour 9:20 day minute 0 M.

21. I hereby certify that I attended the deceased from Nov 5 to Nov 11 41  
that I last saw him in alive on Nov 11 41  
and that death occurred on the date and hour stated above.

Immediate cause of death Pulmonary Broucheit

Due to Pulmonary Broucheit 4 days

Due to 1700

Other conditions Arteriosclerosis  
(Include pregnancy within 6 months of death)

Major findings: Stomach  
Of operations no other

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?

(Specify type of place)  
, While at work? \_\_\_\_\_ (e) Means of injury C

23. Signature Stine & McClure (M. D. or other)  
Address 900 Galloway Date signed 11/11/41

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

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

Willie H. Bennett, Registered Apprentice No. 282  
working under my personal supervision.

Signed Felix Remy

Licensed Embalmer No. 4127

P. O. Address Marion, Ill.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply 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. 37399  
Registrar's No. ....

Registration District No. 399 Primary Registration District No. 1002

1. PLACE OF DEATH:

(a) County Jackson  
(b) City or town Laneas City  
(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

Edward C. Hummel

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 \_\_\_\_\_

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 75 Months 1 Days \_\_\_\_\_ (If less than one day, hr. \_\_\_\_\_ min. \_\_\_\_\_)

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

10. Usual occupation \_\_\_\_\_

11. Industry of business \_\_\_\_\_

MOTHER FATHER { 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) \_\_\_\_\_ (b) \_\_\_\_\_ (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month \_\_\_\_\_ day \_\_\_\_\_ year \_\_\_\_\_ hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_ 19\_\_\_\_; that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_ 19\_\_\_\_; and that death occurred on the date and hour stated above. Immediate cause of death \_\_\_\_\_

SUPPLEMENTARY

Due to \_\_\_\_\_  
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 No Injury

(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 Ed Hummel (M. D. or other) \_\_\_\_\_  
Address 900 Rialto Bldg Date signed 1/14/42

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

S-37399