

22037

S. No. 2
14-41
7-39
X26390

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. _____

FILED JUL 13 1942 703

Registration District No. _____

Primary Registration District No. 4424

Registrar's No. _____

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

1. PLACE OF DEATH

(a) County Polk

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

(c) Name of hospital or institution: Geo. Dimmitt Memorial Hptl
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 19 (Specify whether _____)

In this community _____
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St. Clair

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

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

(e) Citizen of foreign country? No. (Yes or No)

If yes, name country _____

3. (a) PRINT FULL NAME Dessa (Mabel) Hammons

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

4. Sex F. 5. Color or race W.

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

6. (b) Name of husband or wife Freeman Hammons

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

7. Birth date of deceased Oct. 7 1908
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day

34 7 4 _____ hr. _____ min.

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

10. Usual occupation Housewife

11. Industry or business _____

MOTHER FATHER {

12. Name Charlie Bishop

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

14. Maiden name Jessie Kearney

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

16. (a) Informant Mrs Linnie Bishop

(b) Address Collins, Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof June 20-42
(Month) (Day) (Year)

(c) Place: burial or cremation Georgetown Cemetery

18. (a) Signature of funeral director Joseph B. Stuber

(b) Address Humansville, Mo.

19. (a) June 26-42 (Date received local registrar) (b) Geo M. Rich (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 23
year 1942 hour 1:00 minute _____ P. M.

21. I hereby certify that I attended the deceased from June 11-1942
19 to June 23 1942
that I last saw her alive on June 23 1942
and that death occurred on the date and hour stated above.

Immediate cause of death Acute Nephritis

Duration 3 days

Due to _____

Due to _____

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

Major findings: none

Of operations _____

Of autopsy none

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 A J Stupp (M. D. or other) _____

Address Humansville Mo Date signed 6-24-42

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

1178

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED

District Health Officer No. 7,

District File Number 7-42-738

Date Filed 7-10-42

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 Ralph A. Joseph

Licensed Embalmer No. 3149

P. O. Address Humansville

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.

Registration District No. 703

Primary Registration District No. 4424

Registrar's No.

1. PLACE OF DEATH:

(a) County Dalk
(b) City or town Humansville
(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 Theresa M. Hammons

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex F 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 34 Months 7 Days _____ (If less than one day) _____ min.

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

10. Usual occupation _____

11. Industry of 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) _____ (b) _____ (Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June Day _____ Year 1942 Hour _____ Minute _____ M.

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

Due to acute - nephritis

Due to chronic nephritis

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 A. J. Stuppelbauer (M. D. or other) _____

Address Humansville Mo Date signed 8/2/42

SUPPLEMENTARY

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

MOTHER FATHER

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

S-22037