No. 2
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X26390

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED MAY 3 1943

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 13200

Registration District No. 149 | Primary Registration District No. 1002 | Registrar's No. 1631

1. PLACE OF DEATH:
(a) County: JACKSON
(b) City or town: KANSAS CITY
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 4031 Harrison
(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): 20 years
In this community: 20 years

2. USUAL RESIDENCE OF DECEASED:
(a) State: Mo (b) County: Jackson 213
(c) City or town: KANSAS CITY 8
(If outside city or town limits, write "RURAL")
(d) Street No.: 3803 WASHINGTON
(If rural, give location)
(e) Citizen of foreign country: [illegible] (Yes or No)
If yes, name country: Sweeden

3. (a) PRINT FULL NAME: HAMMER CHARLES
3. (b) If veteran, name war: no
3. (c) Social Security No.: 497-14-297
4. Sex: Male
5. Color or race: Wh
6. (a) Single, widowed, married, divorced: Single
6. (b) Name of husband or wife:
6. (c) Age of husband or wife if alive: years
7. Birth date of deceased: FEB (Month) 1 (Day) 1881 (Year)

8. AGE: Years 62 | Months 2 | Days 4 | If less than one day: — hr. min.

9. Birthplace: Sweeden (City, town, or county) (State or foreign country)
10. Usual occupation: Laborer
11. Industry or business:
FATHER 12. Name: Unknown
13. Birthplace: (City, town, or county) (State or foreign country)
MOTHER 14. Maiden name: Unknown
15. Birthplace: (City, town, or county) (State or foreign country)
16. (a) Informant: Mrs O C Heldeman
(b) Address: 3803 Washington
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: 4-7-43 (Month) (Day) (Year)
(c) Place: burial or cremation: Maple Hill KCKS
18. (a) Signature of funeral director: SUNDARTH
(b) Address: K-C Mo
19. (a) 4/6/43 (Date received local registrar) (b) M. M. Brown (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 4 day 5 year 43 hour 10 minute 30 A. M.
21. I hereby certify that I attended the deceased from [illegible], 19__, to [illegible], 19__;
that I last saw him alive on [illegible], 19__;
and that death occurred on the date and hour stated above.

Immediate cause of death: Arteriosclerotic heart disease
Due to: [illegible]
Due to:
Other conditions (Include pregnancy within 3 months of death):
Major findings: Of operations:
Of autopsy: Inspection & history

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:
(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:
23. Signature: [illegible] (M.D. or other)
Address: [illegible] Date signed: [illegible]

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(Licensed Embalmer's Statement on Reverse Side)

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. 2806

P. O. Address 6900 Troost

K. C. Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply wit the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.