

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

FILED SEP 13 1943  
Registration District No. 1000

Primary Registration District No. 3000

1. PLACE OF DEATH:  
(a) County Adair  
(b) City or town Farksville  
(c) Name of hospital or institution Sam Smith  
(d) Length of stay: In hospital or institution Life time  
In this community Life time

2. USUAL RESIDENCE OF DECEASED:  
(a) State Mo. (b) County Adair  
(c) City or town Rural  
(d) Street No. \_\_\_\_\_  
(e) Citizen of foreign country? \_\_\_\_\_

3. (a) PRINT FULL NAME J. V. A. HAMMONS  
3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex Female 5. Color or race White 6. (a) Single, widowed, (married), divorced, married  
6. (b) Name of husband or wife Alford Hammons 6. (c) Age of husband or wife if alive, \_\_\_\_\_ years  
7. Birth date of deceased Aug 5 1882

8. AGE: Years 61 Months - Days 29 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace Rural Mo.

10. Usual occupation House Keeper

11. Industry or business \_\_\_\_\_

MOTHER FATHER { 12. Name Wm Morris  
13. Birthplace unknown  
14. Maiden name Mary Phipps  
15. Birthplace unknown

16. (a) Informant Alfred Hammons

(b) Address Green Castle Mo

17. (a) Burial (b) Date thereof 9/6/43

(c) Place: burial or cremation Novinger

18. (a) Signature of funeral director Dennis Powell

(b) Address Farksville Mo

19. (a) 9/6/43 (b) Mrs. J. H. Aquard

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month September 4th  
year 1943 hour 6 minute 45 P.M.

21. I hereby certify that I attended the deceased from August 11th 1943 to Sept 4 1943; that I last saw her alive on Sept 4 1943; and that death occurred on the date and hour stated above.

Immediate cause of death - Injury producing Gangrenous infected foot

Due to arteriosclerosis

Due to Diabetes

Other conditions 1952  
(Include pregnancy within 3 months of death)

Major findings: Of operations occlusion of arteries at art. ankle  
Of autopsy \_\_\_\_\_

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) Accident (C. O.A.)

(b) Date of occurrence August July 20 1943

(c) Where did injury occur? Adair Mo

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

While at work? Yes (Specify type of place) \_\_\_\_\_ (c) Means of injury Road in front

23. Signature George E. Grinn (M. D. or other) MD

Address Farksville Mo Date signed 9-6-43

Duration 7 weeks  
PHYSICIAN \_\_\_\_\_  
Underline the cause to which death should be charged statistically.

RECEIVED

District Health Officer No. 10

District File Number 9-43-1502

Date Filed SEP 10 1943

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 W. C. Summers

Licensed Embalmer No. 2159

P. O. Address Turksville Mo

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.