7. S. No. 2
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WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

18102

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED JUN 7 1945

Registration District No. 317

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 6076

State File No.

Registrar's No. 123

1. PLACE OF DEATH: (a) County St. Louis County
(b) City or town Jefferson Barracks
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Veterans Administration Facility
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution Adm. Oct. 20, 1944 (Specify whether
In this community fifty years
years, months or days)

2. USUAL RESIDENCE OF DECEASED: (a) State Missouri (b) County
(c) City or town St. Louis
(If outside city or town limits, write "RURAL")
(d) Street No. 4538 Scott Avenue
(If rural, give location)
(e) Citizen of foreign country? - (Yes or No)
If yes, name country -

3. (a) PRINT FULL NAME HAMMEL, William H.

3. (b) If veteran, name war World War #1

3. (c) Social Security No. 486-18-3493

4. Sex male

5. Color or race white

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

6. (b) Name of husband or wife Mrs. Carrie Hammel

6. (c) Age of husband or wife if alive 39 years

7. Birth date of deceased February (Month) 23, (Day) 1894 (Year)

8. AGE: Years 51 | Months 2 | Days 4 | If less than one day hr. min.

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

10. Usual occupation Farmer

11. Industry or business -

MOTHER FATHER

12. Name William Hammel

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

14. Maiden name Mary Barton

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

16. (a) Informant Clinical Records,
(b) Address Vet. Adm. Fac., Jeff. Brks., Mo.

17. (a) Removal (Burial, cremation, or removal) (b) Date thereof 4-27-45 (Month) (Day) (Year)
(c) Place: burial or cremation Dexter, Missouri

18. (a) Signature of funeral director Albert H. Hoppe
(b) Address 4700 Washington Blvd.

19. (a) MAY 2 1945 (Date received local registrar) (b) E. C. McPherson (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 27th, year 1945 hour 12:45 minute P. M.

21. I hereby certify that I attended the deceased from October 20, 1944 to April 27, 1945
that I last saw him alive on April 27, 1945
and that death occurred on the date and hour stated above.

Immediate cause of death CANCER OF THE PANCREAS. — Duration UNKNOWN

Due to -

Due to -

Other conditions None.
(Include pregnancy within 3 months of death)

Major findings:
Of operations Celiotomy, Nov. 29, 1944.
Biopsy, Nov. 29, 1944.
Of autopsy No autopsy.

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) no
(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 E. V. Edwards (M. D. or other)
Address CLINICAL DIRECTOR. Date signed 4/27/45

(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 [signature]

Licensed Embalmer No. 1861

P. O. Address .....

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.