V. S. No. 2
DM—9-4-41
Rev. 5-17-39
I X29484

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

FILED OCT 4 1945

State File No. 30138

Registration District No. 42

Primary Registration District No. 1000

Registrar's No. 998

1. PLACE OF DEATH:

(a) County Buchanan

(b) City or town St Joseph
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: State Hosp #2
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 3 mo. 22 day (Specify whether)

In this community 3 mo ~~22 ta~~ Life time
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Buchanan 11

(c) City or town St Joseph 1
(If outside city or town limits, write "RURAL")

(d) Street No. 1203 N. 7th 7
(If rural, give location)

(e) Citizen of foreign country? (Yes or No) 0

If yes, name country

3. (a) PRINT FULL NAME Lawrence W. Hamm

3. (b) If veteran, name war ✓

3. (c) Social Security No. 491-10-9444

4. Sex M 0

5. Color or race W.

6. (a) Single, widowed, married, divorced 1

6. (b) Name of husband or wife GENEVA Geneva Hamm

6. (c) Age of husband or wife if alive 42 years

7. Birth date of deceased Dec (Month) 4 (Day) 1901 (Year)

8. AGE: Years 43 Months 9 Days 12 If less than one day ___ hr. ___ min.

9. Birthplace St Joseph (City, town, or county) Mo (State or foreign country) 0

10. Usual occupation Laborer

11. Industry or business

FATHER
12. Name Lafe Hamm
13. Birthplace Mo (City, town, or county) (State or foreign country) 0

MOTHER
14. Maiden name Louise Kendall
15. Birthplace Ind (City, town, or county) (State or foreign country) 1

16. (a) Informant Mrs Geneva Hamm

(b) Address 1203 N. 7th St Joseph Mo

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 19, 1945 (Month) (Day) (Year)

(c) Place: burial or cremation Mt. Auburn Cemetery

18. (a) Signature of funeral director Mrs. E. R. Sidenfeden

(b) Address North 10th Street

19. (a) 9-20-45 (Date received local registrar) (b) [signature] (Registrar's signature)

1428

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept day 16 year 1945 hour 8 20 minute P M.

21. I hereby certify that I attended the deceased from May 25, 1945 to Sept 16, 1945 that I last saw him alive on Sept 16, 1945 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Meningo Encephalitis Syphilitica	year
Due to Syphilis	
Due to	
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations
Of autopsy 20 ?

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 L. F. Thuck (M. D. or other)

Address State Hosp #2 Date signed Sept 16/45

(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 Mollie E. Sidenfaden Fox

Licensed Embalmer No. 4235

P. O. Address St. Joseph, 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.