V. S. No. 2
100M—5-43
Rev. 5-17-39
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED OCT 25 1945

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No.

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 9072

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

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17
9

1. PLACE OF DEATH:

(a) County

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

(c) Name of hospital or institution:
Homer G Phillips Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 48 days (Specify whether
In this community 30 years
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County 000

(c) City or town St. Louis, 2 | 17
(If outside city or town limits, write "RURAL")

(d) Street No. 3121 Sheridan 9
(If rural, give location) 0

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

If yes, name country

3. (a) PRINT FULL NAME Sarah Hamm

3. (b) If veteran, name war -

3. (c) Social Security No. -

4. Sex Female 3

5. Color or race Col.

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

6. (b) Name of husband or wife William Hamm

6. (c) Age of husband or wife if alive 50 years

7. Birth date of deceased 1 - 22 - 1903
(Month) (Day) (Year)

8. AGE: Years 42 Months 8 Days 26 If less than one day hr. min.

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

10. Usual occupation Housework

11. Industry or business In home at 4615 Pershing

FATHER
12. Name Nelson Ross
13. Birthplace Columbus (City, town, or county) Miss. (State or foreign country)

MOTHER
14. Maiden name Fannie Johnson
15. Birthplace Columbus (City, town, or county) Miss. (State or foreign country)

16. (a) Informant Fannie Ross -mother
(b) Address 3121 Sheridan Ave. St. Louis

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-22-1945 (Month) (Day) (Year)
(c) Place: burial or cremation Wash. Park Cemetery

18. (a) Signature of funeral director Marie Riley
(b) Address 3759 Finney Ave. St. Louis, Mo.

19. OCT 20 1945 (Date received by registrar) 1945 J. F. Bredeck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct. day 18
year 1945 hour 8 minute 54 A M.

21. I hereby certify that I attended the deceased from Aug. 31, 1945, to Oct. 18, 1945;
that I last saw her alive on Oct. 18, 1945;
and that death occurred on the date and hour stated above.

Immediate cause of death Degenerative Heart Disease with Congestive Failure Right Lobar Pneumonia

Due to

Due to

Other conditions Right Pleural Effusion
(Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy No

Duration
Unk

108

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 Chas. Atkinson (M. D. or other)

Address 2601 N Whittier Date signed 10/19/45

(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 Lawrence E Walker

Licensed Embalmer No. 4341

P. O. Address 4431 Garfield

St Louis 13 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.