

No. 2  
5-43  
-17-39  
X36671

State File No. ....

FILED OCT 19 1945  
Registration District No. 383

Primary Registration District No. 3-0375-656

Registrar's No. 8

1. PLACE OF DEATH:

(a) County Lawrence  
(b) City or town Ash Grove Rural  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: Home  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether)  
In this community 25 yrs years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Lawrence  
(c) City or town Mt Vernon Mo Rural  
(If outside city or town limits, write "RURAL")  
(d) Street No. \_\_\_\_\_  
(If rural, give location) \_\_\_\_\_  
(e) Citizen of foreign country? No (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME James Preston Hammons

3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex M 5. Color or race W 6. (a) Single, widowed, married, divorced married

6. (b) Name of husband or wife Oda 6. (c) Age of husband or wife if alive 5 years

7. Birth date of deceased Sept 5 1885  
(Month) (Day) (Year)

8. AGE: Years 59 Months 11 Days 29 If less than one day hr. min.

9. Birthplace Christians Co Mo  
(City, town, or county) (State or foreign country)

10. Usual occupation Farmer

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

12. Name Isaac Hammons

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

14. Maiden name Nancy Adams

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

16. (a) Informant Oda Hammons

(b) Address Ash Grove Mo

17. (a) Burial (b) Date thereof 9 6 1945  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Mt Olive Mausoleum

18. (a) Signature of funeral director May L Jassett

(b) Address mt Vernon Mo

19. (a) 9-7-45 (b) C.R. Albrecht  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept day 4  
year 1945 hour 12 minute 30 M.

21. I hereby certify that I attended the deceased from July 28, 1945 to Sept 4, 1945  
that I last saw him alive on Sept 2, 1945  
and that death occurred on the date and hour stated above.

Immediate cause of death Blood stream infection exact nature undetermined Duration 1 MO

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions (include pregnancy within 3 months of death) \_\_\_\_\_

Major findings: Of operations no

Of autopsy no

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? \_\_\_\_\_

While at work? \_\_\_\_\_ (Specify type of place) (e) Means of injury \_\_\_\_\_

23. Signature P A Halmer (M. D. or other) \_\_\_\_\_

Address Meriden Mo Date signed 9-5-45

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

MOTHER FATHER

**RECEIVED**

District Health Officer No. 6,

District File Number 10457015

Date Filed OCT 10 1945

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**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..... Max L. Fossett.....

Licensed Embalmer No. 4252

P. O. Address: Ind. Vernon T

**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.

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. Nov  
v-b  
Registrars No. 8

Registration District No. 383 Primary Registration District No. 5656

1. PLACE OF DEATH:  
(a) County Lawrence  
(b) City or town Rural Ozark sup  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether  
In this community \_\_\_\_\_ years, months or days)

2. USUAL RESIDENCE OF DECEASED:  
(a) State MO (b) County Lawrence  
(c) City or town Rural  
(If outside city or town limits, write "RURAL")  
(d) Street No. \_\_\_\_\_ (If rural, give location)  
(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME James P. Hammon  
3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex m 5. Color or race w  
6. (a) Single, widowed, married, divorced \_\_\_\_\_  
6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_

7. Birth date of deceased Sept 5  
(Month) (Day) (Year)  
8. AGE: Years 59 Months \_\_\_\_\_ Days \_\_\_\_\_ If less than one day  
hr. \_\_\_\_\_ min. \_\_\_\_\_

9. Birthplace \_\_\_\_\_ (City, town, or county) \_\_\_\_\_ (State or foreign country)

10. Usual occupation \_\_\_\_\_

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

12. Name James Hammon

13. Birthplace MO (City, town, or county) \_\_\_\_\_ (State or foreign country)

14. Maiden name Nancy Adams

15. Birthplace Adams (City, town, or county) \_\_\_\_\_ (State or foreign country)

16. (a) Informant Oda Hammon MO

(b) Address Ark Stone, MO

17. (a) (Burial, cremation, or removal) \_\_\_\_\_ (b) Date thereof 9-6-45  
(Month) (Day) (Year)

(c) Place: burial or cremation mt Oliv' Memorial

18. (a) Signature of funeral director mt Vernon, MO  
(b) Address \_\_\_\_\_

19. (a) \_\_\_\_\_ (b) Ch. S. Buma  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept year 1945 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_ to \_\_\_\_\_, 19\_\_\_\_; that I last saw him \_\_\_\_\_ and that death occurred on the date and hour stated above. Immediate cause of death \_\_\_\_\_

Due to Blood stream infection Diagnosis Nature undetermined 1 mo.

Due to \_\_\_\_\_  
Other conditions \_\_\_\_\_ (Include pregnancy within 3 months of death)

Major findings: Of operations \_\_\_\_\_

Of 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) \_\_\_\_\_

(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 P.A. Holmes (M. D. or other) 9-5-45  
Address mt Vernon, MO Date signed \_\_\_\_\_

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

SUPPLEMENTARY

34111

No Package to  
compare with  
GFD