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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 8854

FILED APR 6 1946

Registration District No. 73

Primary Registration District No. 291

Registrar's No. 21

1. PLACE OF DEATH:

(a) County CLAY

(b) City or town Liberty Rural Sup.
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: 1007 Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 0
(Specify whether)

In this community 2 mo
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State MO (b) County Clark

(c) City or town Swinston
(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 John Thomas Hammer

3. (b) If veteran name war 70

3. (c) Social Security No. 70

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 8
year 1946 hour 11 minute 10 P.M.

21. I hereby certify that I attended the deceased from Mar 2 1946 to Mar 8 1946
that I last saw h. in alive on Mar 8 1946
and that death occurred on the date and hour stated above.

4. Sex 0 m 5. Color or race W

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

6. (b) Name of husband or wife -

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

7. Birth date of deceased Feb 17 1862
(Month) (Day) (Year)

Immediate cause of death General Atherosclerosis

Due to 15 yrs.

Due to -

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

8. AGE: Years 84 Months 0 Days 21 If less than one day - hr. - min.

9. Birthplace Jackson Township Clark, Mo.
(City, town, or county) (State or foreign country)

10. Usual occupation Retired

PHYSICIAN -

Underline the cause to which death should be charged statistically.

Major findings: Of operations 97

Of autopsy -

MOTHER FATHER

11. Industry or business -

12. Name Robert Hammer

13. Birthplace Missouri Ut. Vir.
(City, town, or county) (State or foreign country)

14. Maiden name Lizzie Day

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

16. (a) Informant J. E. Thomas Sept

(b) Address Liberty Mo

17. (a) Burial (b) Date thereof 3/11/46
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation 1007 cemetery

18. (a) Signature of funeral director James Nell Funeral Home

(b) Address Liberty Mo

19. (a) March 7, 1946 (b) Miriam Haynes
(Data received local registrar) (Registrar's signature)

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 0

23. Signature Burton Malley (M. D. or other) MD
Address Liberty Mo Date signed 3-2-46

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

RECEIVED

District Health Officer No. 8:

District File Number

Date Filed 4-4-46

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.....

Self, Registered Apprentice No.
working under my personal supervision.

Signed *Victor E. Iminger*

Licensed Embalmer No. *2896*

P. O. Address *Liberty 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.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUSTHE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATHState File No. AprilRegistration District No. 73Primary Registration District No. 5291Registrar's No. 21

1. PLACE OF DEATH:

(a) County Clay
(b) City or town Rural
(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 whetherIn this community _____
years, months or days)3. (a) PRINT
FULL NAME John W. Hammer

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 Single6. (b) Name of husband or wife none 6. (c) Age of husband or wife if alive none years7. Birth date of deceased Feb 17
(Month) (Day) (Year)8. AGE: Years 84 Months 0 Day _____ If less than one day
hr. _____ min. _____9. Birthplace _____
(City, town, or county) (State or foreign country) mo10. Usual occupation Retired11. Industry or business none12. Name _____
13. Birthplace _____
(City, town, or county) (State or foreign country)14. Maiden name _____
15. Birthplace _____
(City, town, or county) (State or foreign country)16. (a) Informant _____
(b) Address _____17. (a) _____ (b) Date thereof _____
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (b) Minnie Haynes
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County _____

(c) City or town _____
(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 _____

MEDICAL CERTIFICATE

20. DATE OF DEATH: Month _____
year 1946 hour _____ minute _____ M.21. I hereby certify that I attended the deceased from _____
to _____, 19____;

that I last saw him/her alive on _____, 19____;

and that death occurred on the date and hour stated above.

Immediate cause of death _____

Duration

Due to _____

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 sta-
tistically.

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 _____ (M. D. or other) _____

Address _____ Date signed _____

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

SUPPLEMENTARY

8854