

National Office of Vital Statistics

FILED JUL 19 1948

Registration District No. 200

Primary Registration District No. 5388

Registrar's No. 45

1. PLACE OF DEATH:

(a) County DeWitt
 (b) City or town Shaw 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 all of his life (Specify whether years, months or days)

3. (a) PRINT FULL NAME CHARLES HAMMOND

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex MO 5. Color or race W
 6. (a) Single, widowed, married, divorced M
 6. (b) Name of husband or wife unknown 6. (c) Age of husband or wife if alive 3 years (Day) (Year)
 7. Birth date of deceased Jan 3 1894
 (Month) (Day) (Year)

8. AGE: Years 44 Months 5 Days 29 If less than one day hr. min.

9. Birthplace Jenni
(City, town, or county) (State or foreign country)10. Usual occupation Farmer

11. Industry or business

12. Name John Hammond13. Birthplace Jenni
(City, town, or county) (State or foreign country)14. Maiden name Mary - unknown15. Birthplace unknown
(City, town, or county) (State or foreign country)16. (a) Informant Mrs Charles Hammond(b) Address Sligo, Mo17. (a) Burial (b) Date thereof 7-4-48
(Burial, cremation, or removal) (Month) (Day) (Year)(c) Place: burial or cremation Sligo, Cem.18. (a) Signature of funeral director L. J. Janssen(b) Address Steelville, Mo19. (a) July 10 - 48 (b) M. M. Hart M.D.
(Date received local registrar) (Registrar's Signature)20. DATE OF DEATH: Month July day 2nd
year 1948 hour 8:00 minute P.M.21. I hereby certify that I attended the deceased from Feb 20, 1947, to Jan 1, 1948
that I last saw him alive on Jan 8, 1948
and that death occurred on the date and hour stated above.Immediate cause of death arteriosclerotic heart disease years

Due to

Due to

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations MI

Of autopsy

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County DeWitt 33
 (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? no (Yes or No)
 If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 2nd
year 1948 hour 8:00 minute P.M.21. I hereby certify that I attended the deceased from Feb 20, 1947, to Jan 1, 1948
that I last saw him alive on Jan 8, 1948
and that death occurred on the date and hour stated above.Immediate cause of death arteriosclerotic heart disease years

Due to

Due to

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations MI

Of autopsy

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)

23. Signature M. M. Hart, M.D. (M.D. or other) MDAddress Salem, Mo Date signed 7-10-48

PHYSICIAN

Underline the cause of which death should be charged statistically.

MOTHER FATHER

RECEIVED 7-12-48
District Health Officer No. 5,
District File Number 748459
Date Filed 7-12-48

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 _____

C. Jesse Gahr

Registered Apprentice No. _____

working under my personal supervision.

Signed _____

C. Jesse Gahr

Licensed Embalmer No. *4486*

P. O. Address *Steekville, 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.

2B
-45
43880

State File No. _____

Registration District No. 100

Primary Registration District No. 5-388

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Deer
(b) City or town Sligo 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 whether _____)

In this community _____
years, months or days

3. (a) PRINT FULL NAME Charles Hammond

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 Jan 3
(Month) (Day) (Year)

8. AGE: Years 74 Months 5 Days _____ If less than one day _____ min. _____

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

10. Usual occupation _____

11. Industry or business _____

12. 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) _____
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County _____

(c) City or town Sligo 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 _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month _____
year 1948 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ to _____, 19____;

that I last saw him _____ 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 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 _____ (M. D. or other) _____

Address _____ Date signed _____

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

SUPPLEMENTARY

MOTHER FATHER

S-22702