

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

FEDERAL SECURITY AGENCY
 National Office of Vital Statistics
FILED OCT 30 1948
 Registration District No. **318**

MISSOURI DIVISION OF HEALTH
 STANDARD CERTIFICATE OF DEATH
1003
 Primary Registration District No. **1003**

State File No. **34209**
8997
 Registrar's No. _____

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:
3657a Bates Street
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution.....
(Specify whether years, months or days)
 In this community **Life**

2. USUAL RESIDENCE OF DECEASED:
 (a) State **Missouri** (b) County **000**
 (c) City or town **St. Louis**
(If outside city or town limits, write "RURAL")
 (d) Street No. **3657a Bates Street**
(If rural, give location)
 (e) Citizen of foreign country? **No** (Yes or No)
 If yes, name country.....

3. (a) PRINT FULL NAME **CHARLES HAMMOND SR.**
 3. (b) If veteran, name war..... 3. (c) Social Security No. **489-09-5727**
 4. Sex **Male** 5. Color or race **White** 6. (a) Single, widowed, married, divorced **Widowed**
 6. (b) Name of husband or wife **Augusta Hammond** 6. (c) Age of husband or wife if alive..... years
 7. Birth date of deceased **October 30-1883**
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	64	11	14	hr. min.

9. Birthplace **St. Louis, Missouri**
(City, town, or county) (State or foreign country)
 10. Usual occupation **Retired**
 11. Industry or business.....
 12. Name **Peter Hammond**
 13. Birthplace **St. Louis, Missouri**
(City, town, or county) (State or foreign country)
 14. Maiden name **Unknown**
 15. Birthplace **Unknown**
(City, town, or county) (State or foreign country)
 16. (a) Informant **Melba Culinovic**
3657a Bates Street
 (b) Address.....
 17. (a) **Burial** (b) Date thereof **10-18-1948**
(Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation **New St. Marcus**
 18. (a) Signature of funeral director **W. J. Lasater**
1926 Allen Avenue
 (b) Address.....
 19. (a) **OCT 18 1948** (b) **J. B. Lasater**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION
 20. DATE OF DEATH: Month **October** day **14th**
 year **1948** hour **3** minute **00** P. M.
 21. I hereby certify that I attended the deceased from **Jan 12th**
 19**47** to **Oct 14th** 19**48**
 that I last saw him alive on **Sept 29th** 19**48**;
 and that death occurred on the date and hour stated above.

Immediate cause of death **Chronic Hypertension Heart**
Arteriosclerosis
 Due to.....
 Due to.....
 Other conditions.....
(Include pregnancy within 3 months of death)

Duration
15 months
15 months
 PHYSICIAN
 Underline the cause of which death should be charged statistically.

Major findings:
 Of operations.....
 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)
 While at work?..... (e) Means of injury.....
 23. Signature **Halter B. Lunn** (M. D. or other) **MD**
 Address **5003 A** Date signed **10/15/48**

Halter B. Lunn

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.....

Me

Registered Apprentice No.....

working under my personal supervision.

Signed

Benj. C. Duncan

Licensed Embalmer No. 2272

P. O. Address 1926 Allen Avenue

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.