

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. **4107**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
b. CITY (If outside corporate limits, write RURAL and give town or township) <b>St. Louis</b>		a. STATE <b>Missouri</b> b. COUNTY <b>St. Francois</b>	
c. LENGTH OF STAY (In this place) <b>3da</b>		c. CITY (If outside corporate limits, write RURAL and give township) <b>Flat River,</b>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>Mo Baptist Hosp</b>		d. STREET ADDRESS (If rural, give location) <b>122 Roosevelt</b>	

3. NAME OF DECEASED (Type or Print)			4. DATE OF DEATH (Month) (Day) (Year)			
a. (First) <b>George</b>	b. (Middle) <b>S.</b>	c. (Last) <b>Hammack</b>	<b>May 3, 1950</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Widowed</b>	8. DATE OF BIRTH <b>Feb-7-1874</b>	9. AGE (In years less birthday) <b>76</b>	IF UNDER 1 YEAR <b>2</b> Months	IF UNDER 24 HRS. <b>26</b> Days
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>retired miner</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>lead</b>	11. BIRTHPLACE (State or foreign country) <b>Wayne Co. Mo.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>	

13a. FATHER'S NAME <b>Unknown</b>	13b. MOTHER'S MAIDEN NAME <b>Unknown</b>	14. NAME OF HUSBAND OR WIFE <b>Lillian Hammack</b>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>	16. SOCIAL SECURITY NO. <b>none</b>	17. INFORMANT'S SIGNATURE OR NAME ADDRESS <b>Euin Highley Flat River, Mo</b>
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)  *This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Chronic Myocarditis</b>		<b>8 years</b>
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.  DUE TO (b) <b>Arteriosclerosis</b>  DUE TO (c) <b>Hypertensive C.V. Disease</b>		<b>or weeks</b>
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		<b>4 years</b>	

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY), (STATE)
<b>21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (m.)</b>	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	<b>21f. HOW DID INJURY OCCUR?</b> <b>H43X</b>

22. I hereby certify that I attended the deceased from **April 30, 1950**, to **May 3, 1950**, that I last saw the deceased alive on **May 3, 1950**, and that death occurred at **10:30 a.m.**, from the causes and on the date stated above.

23a. SIGNATURE (Name or Title) <b>P. D. Newell M.D.</b>	23b. ADDRESS <b>46 r No Taylor St. Louis, Missouri</b>	23c. DATE SIGNED <b>5/5/50</b>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>	24b. DATE <b>May-6-1950</b>	24c. NAME OF CEMETERY OR CREMATORY <b>Masonic Cemetery</b>	24d. LOCATION (City, town, or county) (State) <b>Fredericktown, Mo</b>
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DATE REC'D BY LOCAL REG. <b>MAY 6 1950</b>	REGISTRAR'S SIGNATURE <b>J. B. Lanter</b>	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>SPARKS Flat River, Mo</b>
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

**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.....

Student Embalmer No. ....

working under my personal supervision.

Student .....  
Student Embalmer

Signed.....

*Murphy L. Sparks*

Licensed Embalmer No. ....

*4239*

P. O. Address.....

*Flat River, Me*

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.