

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

24840

State File No. 3173

FILED JUL 17 1953

BIRTH NO. _____		REG. DIST. NO. <u>149</u>		PRIMARY REG. DIST. NO. <u>1002</u>		Registrar's No. _____	
1. PLACE OF DEATH a. COUNTY <u>Jackson</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Jackson</u>			
b. CITY OR TOWN <u>Kansas City</u>		c. LENGTH OF STAY (in this place) <u>2 yrs.</u>		c. CITY OR TOWN <u>Kansas City</u>		d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
d. FULL NAME OF HOSPITAL OR INSTITUTION. <u>St. Mary's Hospital</u>				e. STREET ADDRESS (If rural, give location) <u>3468 3538 Genessee</u>			
3. NAME OF DECEASED (Type or Print) a. (First) <u>CARL</u>		b. (Middle) <u>OSCAR</u>		c. (Last) <u>HAMMER</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>6-22-53</u>	
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Wh</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Widowed</u>		8. DATE OF BIRTH <u>Feb. 6, 1875</u>	
9. AGE (In years last birthday) <u>78</u>		IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 1 HR. Hours _____ Min. _____			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired - Cabinet Maker</u>		10b. KIND OF BUSINESS OR INDUSTRY _____		11. BIRTHPLACE (City and State or Foreign Country) <u>Sweden</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13a. FATHER'S NAME <u>No record</u>		13b. MOTHER'S MAIDEN NAME <u>No record</u>		14. NAME OF HUSBAND OR WIFE <u>Anna Augusta Hammer</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Albert W. Hammer, 4328 Roanoke Pkwy, K.C. MO</u>			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)		MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Septicemia</u>		DUPLICATE OF (b) <u>Cerebral malaria</u>				<u>2 yrs</u>	
*This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.		DUPLICATE OF (c) <u>Arteriosclerotic cerebral</u>				<u>15 yrs</u>	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.						<u>332X</u>	
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
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) _____			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? _____			
22. I hereby certify that I attended the deceased from <u>July</u> , 19 <u>52</u> , to <u>June 22</u> , 19 <u>53</u> , that I last saw the deceased alive on <u>June 21</u> , 19 <u>53</u> , and that death occurred at <u>6:30 A.M.</u> , from the causes and on the date stated above.							
23. SIGNATURE <u>John R. Whitteman</u> (Degree or title) <u>MD</u>				23b. ADDRESS <u>6314 Brookside Plaza</u>		23c. DATE SIGNED <u>6-22-53</u>	
24. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		24b. DATE <u>6-22-53</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Memorial Park</u>		24d. LOCATION (City, town, or county) (State) <u>St. Joseph, Missouri</u>	
DATE REC'D BY LOCAL REG. <u>6-22-53</u>		REGISTRAR'S SIGNATURE <u>Geraldine Smith</u>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>STINE &amp; McCLURE Kansas City, Mo.</u>			

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

Dr. John R. Whitman  
6314 Brookside Plaza  
Ni 6607  
11:30

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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 ....., Student Embalmer No..... working under my personal supervision..

Student.....  
Signature of Student Embalmer

Signed *Gerald Burger*.....

Licensed Embalmer No. *4762*.....

P. O. Address *K. C. 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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.