

FILED APR 2 - 1956

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **10810**
Registrar's No. **2816**

318

1003

BIRTH NO. _____ REG. DIST. NO. _____ PRIMARY REG. DIST. NO. _____

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis		c. CITY OR TOWN St. Louis	
c. LENGTH OF STAY (In this place) 1 day		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 St. Anthony Hospital		e. STREET ADDRESS (If rural, give location) 4629 Wilcox	
3. NAME OF DECEASED (Type or Print) a. (First) Julius b. (Middle) M. c. (Last) Hammer			4. DATE OF DEATH (Month) (Day) (Year) 3/17/56
5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Single	8. DATE OF BIRTH Dec. 5, 1905
9. AGE (In years last birthday) 50		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman	11. BIRTHPLACE (City and State or Foreign Country) St. Louis, Missouri
10b. KIND OF BUSINESS OR INDUSTRY own business		12. CITIZEN OF WHAT COUNTRY? USA	
13a. FATHER'S NAME Julius Hammer		13b. MOTHER'S MAIDEN NAME Anna Nessel	14. NAME OF HUSBAND OR WIFE -----
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 492-10-8052	17. INFORMANT'S SIGNATURE OR NAME Julius Hammer--4629 Wilcox
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, ashenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Perforated Gastric ulcer Marginal ulcer Perforated gastric ulcer Marginal ulcer DUE TO (b) _____ DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Peritonitis Peritonitis	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION 540.1	
20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input 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 **1952** to **Mar 17, 1956**; that I last saw the deceased alive on **Mar 16, 1956** and that death occurred at **5:00a** m., from the causes and on the date stated above.

23. SIGNATURE **R.H. Erlich** (Degree or title) **M.D.** 23b. ADDRESS **3606 Gravois** 23c. DATE SIGNED **Mar 19 56**

24a. BURIAL, CREMATION, REMOVAL **Removal** 24b. DATE **3/20/56** 24c. NAME OF CEMETERY OR CREMATORY **Hiram Cemetery** 24d. LOCATION (City, town, or county) (State) **St. Louis Co., Missouri**

DATE REC'D BY LOCAL REG. **MAR 20 1956** REGISTRAR'S SIGNATURE **Carl Smith** 25. FUNERAL DIRECTOR'S SIGNATURE **Wacker-Helderle** ADDRESS **3634 Gravois**

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.....
Signature of Student Embalmer

Signed.....
Licensed Embalmer No.....
P. O. Address.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (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.