Health, Welfare Public Service

300 -57

FILED SEP 30 1957

THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

31435
STATE FILE NUMBER

Registration District No. 128 Primary Registration District No. 2000 Registrar's No. 920

1. PLACE OF DEATH
a. COUNTY: Greene
b. CITY OR TOWN (If outside corporate limits, give TOWNSHIP only): Springfield — Inside Limits: Yes ☒ No ☐
c. FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT in hospital, give location): Foster Rest Home 1623 N. Irving — Length of stay in this place: 15 Mo.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Missouri b. COUNTY: Green
c. CITY OR TOWN: Springfield — Inside Limits: Yes ☒ No ☐
d. STREET ADDRESS (If outside, give location): 1623 N. Irving — Reside on Farm: Yes ☐ No ☒

3. NAME OF DECEASED (Type or print): First: JAMES Middle: A. Last: HAMMER

4. DATE OF DEATH Month: Sept. Day: 21 Year: 1957

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ **NEVER MARRIED** ☐ **WIDOWED** ☒ **DIVORCED** ☐

8. DATE OF BIRTH: 6 June 1874

9. AGE (In years last birthday): 84 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Employee Beer Distributor

10b. KIND OF BUSINESS OR INDUSTRY: Retired

11. BIRTHPLACE (City and state or country): Missouri

12. CITIZEN OF WHAT COUNTRY? USA

13a. FATHER'S NAME: Unknown

13b. MOTHER'S MAIDEN NAME: Unknown

14. NAME OF HUSBAND OR WIFE: Deceased

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service): No

16. SOCIAL SECURITY NO.: 487-38-9690

17. INFORMANT Address: Nursing Home Records

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Arteriosclerotic Heart Disease — INTERVAL BETWEEN ONSET AND DEATH: Unknown
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b)
DUE TO (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a): Essential Hypertension; Bronchial Asthma 4200

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT ☐ **SUICIDE** ☐ **HOMICIDE** ☐

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year

20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

20f. CITY, TOWN, OR LOCATION COUNTY STATE

21. I attended the deceased ~~from~~ on 9-5-57. Saw deceased on 9-21-57 about ½ hour after death. to and last saw ~~him~~ alive on 9-5-57
Death occurred at 10:30 P.M. on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title): Albert P. Simpson M.D.

22b. ADDRESS: Spgfd. Medical Bldg. Springfield, Missouri

22c. DATE SIGNED: 9-25-57

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE: 9-25-57

23c. NAME OF CEMETERY OR CREMATORY: St. Mary's Cemetery

23d. LOCATION (City, town, or county) (State): Springfield, Mo.

24. FUNERAL DIRECTOR: J. W. Klingner & Co. ADDRESS: Spgfd. Mo.

25. DATE RECD. BY LOCAL REG.: 9-25-57

26. REGISTRAR'S SIGNATURE: Earl Williamson

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

All diseases in Part I must be causally related.

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 ..... Signed .....
Signature of Student Embalmer

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

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.