

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-017368

STATE FILE NUMBER

FILED MAY 19 1958

Registration District No. 42

Primary Registration District No. 1000

Registrar's No. 498

300

1-57

All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

1. PLACE OF DEATH a. COUNTY Buchanan		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE unknown b. COUNTY unknown	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Joseph		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN unknown 0117 Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Mo. Meth. Hosp.		Length of stay in lb 3 days	d. STREET ADDRESS (If outside, give location) unknown Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First HAL Middle P. Last HAMMER			4. DATE OF DEATH Month May Day 5 Year 1958
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> 9 DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 5, 1909
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) laborer		10b. KIND OF BUSINESS OR INDUSTRY railroad	9. AGE (In years last birthday) 48 IF UNDER 1 YEAR Months Days Hours Min.
11. BIRTHPLACE (City and state or country) Muskogee, Okla.		12. CITIZEN OF WHAT COUNTRY? USA	
13a. FATHER'S NAME James Hammer		13b. MOTHER'S MAIDEN NAME Emma Powell	14. NAME OF HUSBAND OR WIFE unknown
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) unknown		16. SOCIAL SECURITY NO. 443-07-8338	17. INFORMANT Address Application at C.B.Q. Railroad Co.
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Cerebral Hemorrhage			INTERVAL BETWEEN ONSET AND DEATH 3 days
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Complications of Fractured Skull Due to Fall			3 days
DUE TO (c) 9035 44			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT <input checked="" type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) Fell on sidewalk	
20c. TIME OF INJURY Hour approx. 6 Month 5 Day 1 Year 1958 a.m. p.m.			
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) sidwalk - 8th Angelique	20f. CITY, TOWN, OR LOCATION COUNTY 131 STATE St. Joseph Buchanan Missouri
21. I attended the deceased from 5/2/58 to 5/5/58 and last saw him alive on 5/4/58 Death occurred at 1:30p. m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) Wm. W. H. ... M.D.		22b. ADDRESS Social Welfare Board 10th & Olive, St. Joseph, Mo.	22c. DATE SIGNED 5/6/58
23a. BURIAL, CREMATION, REMOVAL (Specify) burial	23b. DATE 5/13/1958	23c. NAME OF CEMETERY OR CREMATORY City Cemetery	23d. LOCATION (City, town, or county) (State) St. Joseph, Mo.
24. FUNERAL DIRECTOR ADDRESS Heaton Bowman St. Joseph, Mo.		25. DATE RECD. BY LOCAL REG. May 12, 1958	26. REGISTRAR'S SIGNATURE Wm. Clark Goodale

permy

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 *William Spalberg*

Licensed Embalmer No. *4535*

P. O. Address *295 10th St*

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.