

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-011596  
STATE FILE NUMBER

Registration District No. 317 Primary Registration District No. 541 Registrar's No. 746

REC'D MAR 30 1959

300  
-57

1. PLACE OF DEATH a. COUNTY <b>St. Louis</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>St. Louis</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Clayton</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>Maplewood</b> <u>4534</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>St. Louis Co. Hosp.</b>		Length of stay in lb <b>3 days</b>	d. STREET ADDRESS (If outside, give location) <b>7202 Lyndover</b> Reside on Form Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <b>Charles</b> Middle <b>Almus</b> Last <b>Hammock</b>			4. DATE OF DEATH Month <b>March</b> Day <b>18</b> Year <b>1959</b>		
5. SEX <b>Male</b> <u>0</u>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 23rd 1896</b>	9. AGE (In years last birthday) <b>62</b>	IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Machine Operator</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Steel</b>	11. BIRTHPLACE (City and state or country) <b>Pulaski Co. Mo.</b>	12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13a. FATHER'S NAME <b>Wm. H. Hammock</b>		13b. MOTHER'S MAIDEN NAME <b>Mary Riddle</b>		14. NAME OF HUSBAND OR WIFE <b>Ella B. Hammock</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <b>Yes WWI</b>		16. SOCIAL SECURITY NO. <b>unk.</b>	17. INFORMANT <b>Ella B. Hammock</b> Address <b>Above</b>		

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Thrombosis Right Middle and Anterior Cerebral Arteries</b>		INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <b>Cerebral Arteriosclerosis</b>	
	DUE TO (c) <b>332 X</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>Generalized Arteriosclerosis - Pulmonary Emphysema</b>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>

20a. ACCIDENT <input 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.)	
20c. TIME OF INJURY Hour <u>8:30p</u> Month, Day, Year <u>3-16-1959</u> a.m. p.m.	20d. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
20e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20f. CITY, TOWN, OR LOCATION	COUNTY STATE

21. I attended the deceased from <u>3-16-1959</u> to <u>3-18-1959</u> and last saw her alive on <u>3-18-1959</u> Death occurred at <u>8:30p</u> m on the date stated above; and to the best of my knowledge, from the causes stated.		
22a. SIGNATURE <b>J. H. Harrison, Jr. M.D.</b> (Degree or title)	22b. ADDRESS <b>601 S. Brentwood, Clayton</b>	22c. DATE SIGNED <b>3-19-59</b>

23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	23b. DATE <b>3-19-59</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Local Cemetery</b>	23d. LOCATION (City, town, or county) (State) <b>Richland, Mo.</b>
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24. FUNERAL DIRECTOR <b>JAY B. SMITH, Maplewood, Mo.</b>	25. DATE RECD. BY LOCAL REG. <b>3-20-59</b>	26. REGISTRAR'S SIGNATURE <b>John C. Murphy M.D.</b>
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USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

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 .....  
Signature of Student Embalmer

Signed ..... *H. P. Burgess* .....

Licensed Embalmer No. *4029* .....

P. O. Address. *Maplewood* .....

**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.**