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All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

Morton C. Creditor

THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

59-013320

STATE FILE NUMBER

FILED APR 20 1959 Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 1651

1. PLACE OF DEATH
a. COUNTY Jackson
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Kansas City — Inside Limits Yes [X] No [ ]
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Menorah Medical Center — Length of stay in 1b 41 YRS.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Missouri b. COUNTY Jackson
c. CITY OR TOWN Kansas City — Inside Limits Yes [X] No [ ]
d. STREET ADDRESS (If outside, give location) 615 Indiana — Reside on Farm Yes [ ] No [X]

3. NAME OF DECEASED (Type or print): First Colby Middle CLEVELAND Last Hammon
4. DATE OF DEATH: Month March Day 29th Year 1959
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]
8. DATE OF BIRTH: January 31, 1888
9. AGE (In years last birthday): 71 — 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): SWITCHMAN
10b. KIND OF BUSINESS OR INDUSTRY: K. C. TERMINAL
11. BIRTHPLACE (City and state or country): HEMITITE, Mo.
12. CITIZEN OF WHAT COUNTRY? U.S.A
13a. FATHER'S NAME: COLBY HAMMON
13b. MOTHER'S MAIDEN NAME: MARY
14. NAME OF HUSBAND OR WIFE: MARGARET HAMMON
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: MRS. MARGARET HAMMON Address K. C. Mo.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) — INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Pneumonia - bilateral
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. ~~DUE TO~~ (b) Chronic lymphocytic leukemia
~~DUE TO~~ (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a): 490XH

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 3/28/59 to 3/29/59 and last saw him alive on 3-29-59
Death occurred at 3/29/59 9:A.M. on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) Morton C. Creditor M.D.
22b. ADDRESS 4949 Rockhill Rd
22c. DATE SIGNED 3/31/59

23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL
23b. DATE 4/1/59
23c. NAME OF CEMETERY OR CREMATORY MT. MORIAH CEMETERY
23d. LOCATION (City, town, or county) KANSAS CITY, Mo. (State)

24. FUNERAL DIRECTOR C. H. BLACKMAN & SON INC. ADDRESS K.C. Mo.
25. DATE RECD. BY LOCAL REG. 4-1-59
26. REGISTRAR'S SIGNATURE neva Meinshall

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 W. C. Rinne

Licensed Embalmer No. 4879

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.