

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-022947  
STATE FILE NUMBER

FILED JUL 13 1959

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_ Registrar's No. **6290**

S. 300

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Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

|   |                                  |   |   |   |   |
|---|----------------------------------|---|---|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY  |                                  |   | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Missouri</b> b. COUNTY |   |   |
| b. CITY (If outside corporate limits, give TOWNSHIP only)<br>OR<br>TOWN <b>St. Louis, Missouri.</b>   |                                  | Inside Limits<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>  | c. CITY<br>OR<br>TOWN <b>St. Louis</b>  |   | Inside Limits<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>              |
| c. FULL NAME OF (If NOT in hospital, give location)<br>HOSPITAL OR<br>INSTITUTION <b>Jewish Hospital</b>  |                                  | Length of stay in 1b  | d. STREET<br>ADDRESS <b>3303a Humphrey Street,</b>  |   | Reside on Farm<br>Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>             |
| 3. NAME OF DECEASED<br>(Type or print)<br>First <b>Eugene</b> Middle <b>Harold</b> Last <b>Hammond</b>  |                                  |   | 4. DATE OF DEATH<br>Month <b>June</b> Day <b>30</b> Year <b>1959</b>  |   |   |
| 5. SEX<br><b>Male</b>   | 6. COLOR OR RACE<br><b>White</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>June 21, 1932</b>  | 9. AGE (In years last birthday)<br><b>27</b>          | FUNDER 1 YEAR<br>Months _____ Days _____  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Salesman</b>  |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Real Estate</b>   | 11. BIRTHPLACE (City and state or country)<br><b>Peoria, Illinois.</b>  |   | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |
| 13a. FATHER'S NAME<br><b>Charles Hammond</b>  |                                  | 13b. MOTHER'S MAIDEN NAME<br><b>Marguerite Cullen</b>   |   | 14. NAME OF HUSBAND OR WIFE<br><b>LaVonn Hammond</b>  |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?<br>(Yes, no, or unknown) (If yes, give year or dates of service)<br><b>No</b>  |                                  | 16. SOCIAL SECURITY NO.<br><b>487-32-6249</b>   | 17. INFORMANT<br>Address<br><b>LaVonn Hammond, 3303a Humphrey Street.,</b>  |   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>MYOCARDIAL DAMAGE</b>   |                                  |   |   |   | INTERVAL BETWEEN ONSET AND DEATH  |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. }<br>DUE TO (b) <b>CORONARY ARTERY DISEASE</b>   |                                  |   |   |   |   |
| DUE TO (c) <b>DIABETES MELLITUS</b>   |                                  |   |   |   |   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)<br><b>260+</b>  |                                  |   |   |   | 19. WAS AUTOPSY PERFORMED?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT SUICIDE HOMICIDE<br><input type="checkbox"/> <input type="checkbox"/> <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<br>Hour _____ a.m. _____ p.m.   |                                  |   |   |   |   |
| 20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE WORK <input type="checkbox"/>  |                                  | 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 <b>6-26-59</b> to <b>6-30-59</b> and last saw <sup>her</sup> <sub>him</sub> alive on <b>6-30-59</b><br>Death occurred at <b>6:00</b> p.m. on the date stated above; and to the best of my knowledge, from the causes stated. |                                  |   |   |   |   |
| 22a. SIGNATURE<br><b>Elizabeth M. Stoddard M.D.</b> (Degree or title)   |                                  |   | 22b. ADDRESS<br><b>Jewish Hospital</b>  |   | 22c. DATE SIGNED<br><b>6-30-59</b>  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)   |                                  | 23b. DATE<br><b>7-3-59</b>  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Laurel Hill Gardens</b>  |   | 23d. LOCATION (City, town, or county) (State)<br><b>St. Louis County, Missouri.</b>               |
| 24. FUNERAL DIRECTOR<br><b>Albert H. Hoppe, Inc., 4700 Washington</b>   |                                  | 25. DATE RECD. BY LOCAL REG.<br><b>JUL 2 '59</b>  |   | 26. REGISTRAR'S SIGNATURE<br><b>Loard Smith, M.D.</b> |   |

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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 *Aug W Walker* .....

Licensed Embalmer No. *3575* .....  
P. O. Address. *St Louis* .....

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.