

REGISTRATION DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

60-013805

FILED VS APR 4 1960

STATE FILE NUMBER

Registration District No. 324 Primary Registration District No. 4475 Registrar's No. 68

1. PLACE OF DEATH a. COUNTY Saline				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Saline			
b. CITY (if outside corporate limits, give TOWNSHIP only) OR TOWN Malta Bend		Length of stay in 1b 27 years		c. CITY OR TOWN Malta Bend		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (if NOT in hospital, give location) HOSPITAL OR INSTITUTION Streets not numbered			Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	d. STREET ADDRESS (if outside, give location) Streets not numbered		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last ALONZO ELSWORTH HAMMER				4. DATE OF DEATH Month Day Year March 29, 1960			
5. SEX Male	6. COLOR OR RACE White	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH 3-4-1893	9. AGE (last birthday) 67	IF UNDER 1 YEAR Months Days	IF UNDER 24 HR Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret. Farmer			10b. KIND OF BUSINESS OR INDUSTRY Farm		11. BIRTHPLACE (City and state or country) Montreal, Mo.		12. CITIZEN OF WHAT COUNTRY USA
13a. FATHER'S NAME Confare Hammer			13b. MOTHER'S MAIDEN NAME Theodocia Cooper			14. NAME OF HUSBAND OR WIFE Minnie Parish Hammer	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No			16. SOCIAL SECURITY NO. 500-01-0829		17. INFORMANT Address Mrs. Minnie Hammer, Malta Bend, Mo.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction DUE TO (b) Coronary Occlusion DUE TO (c) Arterio Sclerosis PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" 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 Month, Day, Year 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.)		20f. CITY, TOWN, OR LOCATION		COUNTY		STATE	
21. I attended the deceased from Mar 27 to Mar 29 and last saw him/her alive on Mar 29 Death occurred at 8:22 am. on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Deceased or title) <i>[Signature]</i>				22b. ADDRESS Marshall MO			22c. DATE SIGNED 3-29-60
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 3-31-1960	23c. NAME OF CEMETERY OR CREMATORY Malta Bend Cemetery		23d. LOCATION (City, town, or county) (State) Malta Bend, Mo.		
24. FUNERAL DIRECTOR ADDRESS Campbell-Lewis Marshall, Mo.				25. DATE RECD. BY LOCAL REG. 3-30-60		26. REGISTRAR'S SIGNATURE <i>[Signature]</i>	

(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by _____ or by _____, Student Embalmer No. _____ working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed *James H. Lewis*

Licensed Embalmer No. 4709

P. O. Address Marshall, W. Va.

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.