

MOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=61-037562

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. 282 Primary Registration District No. 5655 Registrar's No. 102 STATE FILE NUMBER

AMENDED

DATE AMENDED

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT
MEDICAL CERTIFICATION
BY AFFIDAVIT OF

FILED NOV 2 1961

1. PLACE OF DEATH
a. COUNTY LAURENCE
b. CITY (if outside corporate limits, give TOWNSHIP only) OR TOWN MT. VERNON Length of stay in 1b 22 days
c. FULL NAME OF (if NOT in hospital, give location) HOSPITAL OR INSTITUTION MO. S. SAN. Inside Limits Yes No

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE MO. b. COUNTY ST. GENEVIEVE
c. CITY OR TOWN FARMINGTON Inside Limits Yes No
d. STREET ADDRESS (If outside, give location) Box 387 Reside on Farm Yes No

3. NAME OF DECEASED (Type or print) First Middle Last 4. DATE OF DEATH Month Day Year
JASPER THOMAS HAMMERS 10 25 61

5. SEX M 6. COLOR OR RACE W 7. Married Never Married Widowed Divorced 8. DATE OF BIRTH 8-17-84 9. AGE (last birthday) 77 IF UNDER 1 YEAR Months 2 Days 8 IF UNDER 24 HR Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABOR 10b. KIND OF BUSINESS OR INDUSTRY FARMING & MINING 11. BIRTHPLACE (City and state or country) ST. GENEVIEVE CO. 12. CITIZEN OF WHAT COUNTRY U.S.A.

13a. FATHER'S NAME JAMES M. HAMMERS 13b. MOTHER'S MAIDEN NAME CATHERINE L. NEEDAM 14. NAME OF HUSBAND OR WIFE MARY HAMMERS

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | (If yes, give war or dates of service) 17. INFORMANT Hosp. Records Address

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) HYPOXIA
DUE TO (b) CARCINOMATOSIS
DUE TO (c)
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.

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.
 Yes No Unknown

INTERVAL BETWEEN ONSET AND DEATH UNKNOWN

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 Month, Day, Year
a.m. p.m.

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 10-4-61 to 10-25-61 and last saw him alive on 10-20-61
Death occurred at 10-25-61 6:5 p on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) Geo. H. Hobler, M.D. 22b. ADDRESS Mo State San 22c. DATE SIGNED 10-26-61

23a. BURIAL, CREMATION, REMOVAL (Specify) Removal 23b. DATE 10-26-61 23c. NAME OF CEMETERY OR CREMATORY Parkview Cemetery 23d. LOCATION (City, town, or county) (State) Farmington Mo.

24. FUNERAL DIRECTOR Cozear F. Home ADDRESS Farmington Mo. 25. DATE RECD. BY LOCAL REG. 10-26-61 26. REGISTRAR'S SIGNATURE Toy Payne

DEC 26 1962

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 Max L. Fouret

Licensed Embalmer No. 4252

P. O. Address M. Vernon

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.