

**MISSOURI STATE BOARD OF HEALTH  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH**

Do not use this space.

18611

**1. PLACE OF DEATH**

County..... Registration District No. 791  
 Township..... Primary Registration District No. 1008  
 City St. Louis, Mo. (No. 2900 Henrietta)

File No. ....  
 Registered No. 4983  
 St. .... Ward)

**2. FULL NAME**

Adelaid Hammer  
 (a) Residence. No. 2900 Henrietta St., 17 Ward.  
 (Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. da. How long in U.S., if of foreign birth? yrs. mos. da. (If nonresident give city or town and State)

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX female 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Henry D. Hammer

6. DATE OF BIRTH (MONTH, DAY AND YEAR) March 15 - 1862

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.  
66 | 1 | 22 | 108  
1320

**8. OCCUPATION OF DECEASED**

(a) Trade, profession, or particular kind of work Housewife  
 (b) General nature of industry, business, or establishment in which employed (or employer) "  
 (c) Name of employer

**9. BIRTHPLACE (CITY OR TOWN)**

(STATE OR COUNTRY) Germany

**10. NAME OF FATHER**

Unknown Use

**11. BIRTHPLACE OF FATHER (CITY OR TOWN)**

(STATE OR COUNTRY) Germany

**12. MAIDEN NAME OF MOTHER**

Unknown

**13. BIRTHPLACE OF MOTHER (CITY OR TOWN)**

(STATE OR COUNTRY) Germany

14. INFORMANT Ma H. Hammer  
 (Address) 2900 Henrietta

15. FILED 7 1928 H. C. Stanley  
 REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) May 7 1928

17. I HEREBY CERTIFY That I attended deceased from May 7 1928 to May 7 1928.  
 that I last saw him alive on May 7, 1928, and that death occurred, on the date stated above, at 11:30 a.m.

**THE CAUSE OF DEATH\* WAS AS FOLLOWS:**

108  
1320  
Labor Pneumonia  
 (duration) yrs. mos. 5 da.

CONTRIBUTORY Pylitis  
 (SECONDARY) (duration) yrs. mos. 6 da.

**18. WHERE WAS DISEASE CONTRACTED**

IF NOT AT PLACE OF BIRTH

DID AN OPERATION PRECEDE DEATH? no DATE OF \_\_\_\_\_

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS? Chloroform & Sublimation

(Signed) Martin J. Seaman, M. D.

577, 1928 (Address) 506 am

\*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Brickey Mo. DATE OF BURIAL May 8 1928

20. UNDERTAKER E. J. Schuur ADDRESS 3125 Lafayette av.

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

