

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.

Registration District No. 1030

Primary Registration District No. 200

State File No. _____

Registrar's No. 2086

1. PLACE OF DEATH:

(a) County Saint Louis

(b) City or town Jefferson Barracks
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
Veterans Administration Facility
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution Adm: 9-7-39
(Specify whether _____)

In this community Unknown
years, months or days

8. (a) PRINT FULL NAME John B. Kaslin 243

8. (b) If veteran, name war World

8. (c) Social Security No. _____

4. Sex Male 5. Color or race White

6. (a) Single, widowed, married, divorced Single

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased January 1, 1892
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day

47 10 26 hr. _____ min.

9. Birthplace Omaha Nebraska
(City, town, or county) (State or foreign country)

10. Usual occupation Mechanic

11. Industry or business _____

12. Name Melchir Kaslin

13. Birthplace Switzerland
(City, town, or county) (State or foreign country)

14. Maiden name Katherine Mueller

15. Birthplace Germany
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature C. W. Hughes, V. A.

(b) Address F., Jefferson Barracks, Mo.

17. (a) Burial (b) Date thereof 11/29/39
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation New SS Peter & Paul Cem

18. (a) Signature of funeral director J. L. Ziegenhein & Sons

(b) Address 7027 Gravois Ave

19. (a) NOV 27 1939 (b) [Signature]
(Date received local registrar) (Registrar's signature)

(Licensed Embalmer's Statement on Reverse Side)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County _____

(c) City or town Saint Louis
(If outside city or town limits, write "RURAL")

(d) Street No. 5341 Quincy
(If rural, give location)

(e) If foreign born, how long in U. S. A. ? _____ years

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month November day 27
year 1939 hour 4 minute 20 A. M.

21. I hereby certify that I attended the deceased from September
7, 1939, to November 27, 1939
that I last saw him alive on November 27, 1939
and that death occurred on the date and hour stated above.

Immediate cause of death Addison's Disease with Addisonian crisis. Duration Unkn.

Due to _____

Due to _____

Other conditions None
(Include pregnancy within 3 months of death)

Major findings: No operation

Of operations _____

Of autopsy No autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____

(b) Date of occurrence _____

(c) Where did injury occur? _____ (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at _____ (Specify type of place)

(e) Means of injury _____

23. Signature C. W. Hughes, Chief Med. Officer
(M. D. or other) _____
Address VAF Jefferson Bks., Mo. Date signed 11-27-39

PHYSICIAN

Underline the cause to which death should be charged statistically

68

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.....
....., Registered Apprentice No.....
working under my personal supervision.

Signed.....

Licensed Embalmer No.....

P. O. Address.....

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 this body is not embalmed, above space should be left blank.