

Registration District No. 318

Primary Registration District No. 2001

1. PLACE OF DEATH:

(a) County Greene
 (b) City or town Springfield
 (c) Name of hospital or institution 1400 S. Glenstone
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution X
 In this community 1 year
 years, months or days (Specify whether years, months or days) 2

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Greene
 (c) City or town Springfield
 (If outside city or town limits, write "RURAL")
 (d) Street No. 1400 S. Glenstone
 (If rural, give location)
 (e) If foreign born, how long in U. S. A. ? _____ years.

3. (a) PRINT FULL NAME Carl Kammerer

3. (b) If veteran, name war No. 3. (c) Social Security No. None

4. Sex male 5. Color or race White 6. (a) Single, widowed, married, divorced widowed

6. (b) Name of husband or wife MARY KAMMERER 6. (c) Age of husband or wife if alive Dec years

7. Birth date of deceased August 23 - 1846
 (Month) (Day) (Year)

8. AGE: Years 194 Months 2 Days 29 If less than one day X hr. X min.

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

10. Usual occupation Farmer

11. Industry or business Farm

12. Name Unknown

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

14. Maiden name Baker

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

16. (a) Informant's own signature Albert Kammerer

(b) Address Marshfield Mo

17. (a) Burial (b) Date thereof 11-24-40
 (Burial, cremation, or other) (Month) (Day) (Year)

(c) Place: burial or cremation Mt. Pisgah

18. (a) Signature of funeral director Res Ramsey

(b) Address Marshfield, Missouri

19. (a) 11-24-40 (b) W. E. Hensley
 (Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month November day 22
 year 1940 hour 11 minute 30 p. M.

21. I hereby certify that I attended the deceased from _____, 19____; to _____, 19____; that I last saw him in dead Nov 22 1940 and that death occurred on the date and hour stated above.

Immediate cause of death Chronic Pyelocystitis

Due to Similarity

Due to 1/20

Other conditions (include pregnancy within 3 months of death)

Major findings: Of operations

Of 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 work? _____ (Specify type of place) (e) Means of injury _____

Signature R. M. White (M. D. or other) _____
 Address Courier Jones County Date signed 11/26/40

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE 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.

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, *Tex Fairney*.....
Licensed Embalmer No. *3312*.....

P. O. Address *Marshfield*.....

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.

J