

No. 2
9-4-41
5-17-3
I X2

FILED OCT 10 1942

State File No. _____

Registration District No. 110

Primary Registration District No. 4182

Registrar's No. 73

1. PLACE OF DEATH

(a) County Franklin
(b) City or town Franklin
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether
In this community _____
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State MISSOURI (b) County FRANKLIN
(c) City or town NEW HAVEN
(If outside city or town limits, write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Robert Hallemann

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex Male 5. Color or race W. 6. (a) Single, widowed, married, divorced 0
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if
alive _____ years
7. Birth date of deceased 9 25 1942
(Month) (Day) (Year)

8. AGE: Years _____ Months _____ Days 4 If less than one day
hr. _____ min. _____

9. Birthplace Franklin, Mo.
(City, town, or county) (State or foreign country)

10. Usual occupation _____

11. Industry or business _____

12. Name Fred Hallemann

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

14. Maiden name Mary Ruth

15. Birthplace St. Louis, Mo.
(City, town, or county) (State or foreign country)

16. (a) Informant Fred Hallemann

(b) Address Franklin, Mo.

17. (a) Burial (b) Date thereof 9-30-42
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Catholic Cemetery

18. (a) Signature of funeral director L. H. Heston

(b) Address Franklin, Mo.

19. (a) Sept 7-42 (b) Albert Conrad
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month September, 28
year 1942 hour 7:00 minute A. M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____
that I last saw him _____ alive on _____, 19____
and that death occurred on the date and hour stated above.

Immediate cause of death _____

Due to Congenital Malformation of the Heart

Due to _____

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)
(a) Means of injury 3
23. Signature Gerald P. Ottensmeyer (M. D. or other) Coroner
Address Gerald, Missouri Date signed 9-28-42

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

WRITE PLAINLY - USE UNFADING BLACK INK - MAKE A PERMANENT RECORD

MOTHER FATHER

268

(Licensed Embalmer's Statement on Reverse Side)

ET

1914

111

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 me

Registered Apprentice No.

working under my personal supervision.

Signed

Earl Fertig

Licensed Embalmer No.

3385

P. O. Address

New Haven

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.

8 25

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 30254
Registrar's No. 73

Registration District No. 110

Primary Registration District No. 4182

1. PLACE OF DEATH:

(a) County Franklin
(b) City or town _____
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: _____
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____
(Specify whether _____)
In this community _____
years, months or days

3. (a) PRINT FULL NAME

Robert Hallemann

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

4. Sex M

5. Color or race W

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

6. (b) Name of husband or wife _____

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

7. Birth date of deceased

Sept
(Month)

26
(Day)

1947
(Year)

8. AGE:

Years NO

Months NO

Days NO

If less than one day

min.

9. Birthplace

(City, town, or county)

(State or foreign country)

10. Usual occupation

11. Industry or business

12. Name

13. Birthplace

(City, town, or county)

(State or foreign country)

14. Maiden name

15. Birthplace

(City, town, or county)

(State or foreign country)

16. (a) Informant

(b) Address

17. (a)

(Burial, cremation, or removal)

(b) Date thereof

(Month) (Day) (Year)

(c) Place: burial or cremation

18. (a) Signature of funeral director

(b) Address

19. (a)

(Date received local registrar)

(b)

(Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County _____
(c) City or town _____
(If outside city or town limits, write "RURAL")
(d) Street No. _____
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept Day 28
year 1947 hour _____ minute 9 a.m.

21. I hereby certify that I attended the deceased from _____, 19____;
that I personally saw him/her alive on _____, 19____;
and that death occurred on the date and hour stated above.
Immediate cause of death _____

Duration

Due to _____

Due to _____

Other conditions _____
(Include pregnancy within 3 months of death)

Major findings:

Of operations _____

Of autopsy _____

PHYSICIAN

Underline the cause to which death should be charged statistically.

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)

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

While at work? _____ (Specify type of place)
(c) Means of injury _____

23. Signature _____ (M. D. or other)

Address _____ Date signed _____

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

SUPPLEMENTAL

