

Registration District No. 2

Primary Registration District No. 3019

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

1. PLACE OF DEATH:

(a) County COOPER

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

(c) Name of hospital or institution: ST. JOSEPH'S HOSPITAL
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 9 DAYS (Specify whether years, months or days)

In this community 9 DAYS

2. USUAL RESIDENCE OF DECEASED:

(a) State MISSOURI (b) County COOPER

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

(d) Street No. 12 RIVERSIDE DRIVE
(If rural, give location)

(e) Citizen of foreign country? NO (Yes or No)
If yes, name country: 0

3. (a) PRINT FULL NAME ROBERT CHARLES LAMMERS

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

4. Sex MALE 5. Color or race WHITE 6. (a) Single, widowed, married, divorced, SINGLE

6. (b) Name of husband or wife NONE 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased AUGUST 2 1943
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>0</u>	<u>0</u>	<u>9</u>	hr. _____ min.

9. Birthplace BOONVILLE MISSOURI
(City, town, or county) (State or foreign country)

10. Usual occupation INFANT

11. Industry or business INFANT

12. Name WALTER LAMMERS

13. Birthplace COOPER COUNTY MISSOURI
(City, town, or county) (State or foreign country)

14. Maiden name ALMA LOUISE SCHUSTER

15. Birthplace COOPER COUNTY MISSOURI
(City, town, or county) (State or foreign country)

16. (a) Informant WALTER LAMMERS

(b) Address BOONVILLE, MO.

17. (a) BURIAL (b) Date thereof AUG. 13-1943
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation PILOT GROVE CATHOLIC CEM.

18. (a) Signature of funeral director STEGNER & KOENIG

(b) Address BOONVILLE, MO

19. (a) _____ (b) _____
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month AUGUST day 11th
year 1943 hour 7:15 minute P. M.

21. I hereby certify that I attended the deceased from Aug 2, 1943 to Aug 11, 1943
that I last saw him alive on Aug 11, 1943
and that death occurred on the date and hour stated above.

Immediate cause of death Cystic Degeneration of Kidneys Duration 9 days

Due to Congenital

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?
(Specify type of place)

While at work? _____ (e) Means of injury _____

23. Signature W.H. Bigler (M.D. or other) M.D.

Address Boonville Mo. Date signed 8-12-42

MOTHER FATHER

PHYSICIAN
Underline the cause to which death should be charged statistically.

RECEIVED

District Health Officer No. 8,

District File Number

Date Filed

9-1-43

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

James W. Stegner

Licensed Embalmer No

3780

P. O. Address

Boonville, W.

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, fact should be so stated above.

Registration District No. 82

Primary Registration District No. 3017

Registrar's No. 98

1. PLACE OF DEATH:

(a) County Casper
(b) City or town Boonville
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution St Joseph Hospital
(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) 4 WEEKS

3. (a) PRINT FULL NAME Robert C. Lammey

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 Aug 2 (Month) (Day) (Year)

8. AGE: Years _____ Months _____ Days _____ (Unless than one day) min. _____

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

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) _____ (b) Date thereof _____ (Month) (Day) (Year)
(Burial, cremation, or removal)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) (Aug 12-43) (b) (Dr. Chas. Swap.)
(Date received local registrar) (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 Aug Day 11 Year 1943 Hour _____ Minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____; that I saw him _____ 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)

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

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

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

Address _____ Date signed _____

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

SUPPLEMENTARY

MOTHER FATHER

28003