

Registration District No. 310

Primary Registration District No. 3058

Registrar's No. 170

1. PLACE OF DEATH:
(a) County. ST. CHARLES
(b) City or town. ST. CHARLES
(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 3 DAYS (Specify whether years, months or days)

3. (a) PRINT FULL NAME LEROY C. KAIMANN
3. (b) If veteran, name war. 3. (c) Social Security No.

4. Sex m 5. Color or face w
6. (b) Name of husband or wife 6. (c) Age of husband or wife if alive years
7. Birth date of deceased July 30 1937
(Month) (Day) (Year)

8. AGE: Years 6 Months 7 Days 13 If less than one day hr. min.

9. Birthplace OLD MONROE MO 0
(City, town, or county) (State or foreign country)

10. Usual occupation SCHOOL BOY

11. Industry or business A

12. Name ALVIN KAIMANN
13. Birthplace OLD MONROE MO 0
(City, town, or county) (State or foreign country)
14. Maiden name FAIR
15. Birthplace ST. CHARLES Co. MO 1
(City, town, or county) (State or foreign country)

16. (a) Informant ALVIN KAIMANN
(b) Address OLD MONROE MO

17. (a) BURIAL (Burial, cremation, or removal) (b) Date thereof Oct. 15 43
(Month) (Day) (Year)
(c) Place: burial or cremation OLD MONROE MO

18. (a) Signature of funeral director E. Keithly
(b) Address Stallion MO.

19. (a) 10-14-1943 (Date received local registrar) (b) LeRoy C. Kaimann (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State MO (b) County Lincoln
(c) City or town Old Monroe 0
(If outside city or town limits, write "RURAL")
(d) Street No. (If rural, give location)
(e) If foreign born, how long in U. S. A.? years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month OCTOBER day 13
year 1943 hour minute M.
21. I hereby certify that I attended the deceased from 10/14
1943 to 10/13 1943
that I last saw him alive on 10/13 and that death occurred on the date and hour stated above.

Immediate cause of death Tuberculous meningitis Duration 1 wk.

Due to Pulmonary and milinary TB. ?
Due to

Other conditions (Include pregnancy within 3 months of death) 13 P 1

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?

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

23. Signature (M. D. or other)
Address St. Charles Mo Date signed 10/15/43

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

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..... *E. K. Keithly*

Licensed Embalmer No. *877*

P. O. Address. *Stallow Mo*

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.