

FILED MAY 5 1945
Registration District No. _____

Primary Registration District No. 5428

1. PLACE OF DEATH:

(a) County Franklin

(b) City or town Leslie Mo. 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 Mo. (b) County Franklin

(c) City or town Leslie Mo. 36
(If outside city or town limits, write "RURAL") 0

(d) Street No. _____ (If rural, give location) _____

(e) If foreign born, how long in U. S. A.? 1 years.

3. (a) PRINT FULL NAME David Hartmann

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

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

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

7. Birth date of deceased Jan 22 1860
(Month) (Day) (Year)

8. AGE: Years 85 Months 2 Days 11 If less than one day _____ hr. _____ min.

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

10. Usual occupation Farming

MOTHER FATHER

11. Industry or business _____

12. Name Frith Hartmann

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

14. Maiden name Cora Mae Hartmann

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

16. (a) Informant Joe Hartmann

(b) Address Leslie Mo.

17. (a) Burial (b) Date thereof April 6 1945
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Leslie Mo.

18. (a) Signature of funeral director G. H. Terrence

(b) Address Beaufort Mo.

19. (a) April 6 45 (b) Don O'Brien
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Apr day 3 year 1945 hour 5 minute 30 P. M.

21. I hereby certify that I attended the deceased from Jan 1943 to Apr 3 1945 that I last saw him alive on Apr 1 1945 and that death occurred on the date and hour stated above.

Immediate cause of death Chronic Coronary heart disease

Due to _____

Due to _____

Other conditions General Arteriosclerosis
(Include prognosis 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 work _____ (Specify type of place) (e) Means of injury _____

23. Signature J. H. Matthews M.D. or other _____

Address Beaufort Mo. Date signed 4/4/45

Duration _____

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

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

36
0
0

RECEIVED
District Health Officer No. 9,
District File Number.....
Date Filed 5-4-45

OCT 11 1945

2781
86
11761

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 _____

E. H. Temple, Registered Apprentice No. _____
working under my personal supervision.

Signed

E. H. Temple

Licensed Embalmer No. 3076

P. O. Address Beaufort 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.