

Registration District No. 112

Primary Registration District No. 5425

Registrar's No. 2

1. PLACE OF DEATH:

(a) County..... FRANKLIN

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

(c) Name of hospital or institution: 1
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution..... 55 Years. (Specify whether years, months or days)

In this community..... 55 Years.

2. USUAL RESIDENCE OF DECEASED:

(a) State..... Missouri (b) County..... Franklin 36

(c) City or town..... Sullivan, Rural 0
(If outside city or town limits, write "RURAL")

(d) Street No. Boon Jwp 0
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country.....

3. (a) PRINT FULL NAME ALBERT VITUS KAMLER

3. (b) If veteran, name war..... NO

3. (c) Social Security No..... NONE

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept day 16
year 1945 hour 9 minute 15 A.M.

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

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

7. Birth date of deceased. APRIL 20, 1858
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from 2-10 1945 to 9-16 1945
that I last saw him alive on 9-16 1945
and that death occurred on the date and hour stated above.

8. AGE: Years Months Days If less than one day
87 4 26 hr. min.

Immediate cause of death Cerebral softening 6 months
arteriosclerosis 1 yr.
old age.

9. Birthplace Washington Missouri
(City, town, or county) (State or foreign country)

Other conditions (Include pregnancy within 3 months of death)

10. Usual occupation Farming

11. Industry or business Farming

Major findings: gbc
Of operations.....
Of autopsy.....

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

MOTHER FATHER { 12. Name MARTIN KAMLER

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

{ 14. Maiden name Rosalie Macha

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

16. (a) Informant Della Kamler

(b) Address Sullivan, Missouri.

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?

17. (a) Burial (Burial, cremation, or removal) Japan Cemetery (b) Date thereof Sept. 18, 45
(Month) (Day) (Year)

(c) Place: burial or cremation.....

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

18. (a) Signature of funeral director Thos. J. Hoffa

(b) Address Sullivan, Missouri

19. (a) 9-18-45 (b) J. H. Matthews
(Date received local registrar) (Registrar's signature)

23. Signature L. P. Garner (M. D. or other) 2-20
Address Sullivan, Missouri Date signed 9/17/45

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

RECEIVED

District Health Officer No. 9,

District File Number.....

Date Filed 10-5-45

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 Edgar W. Taffron
Licensed Embalmer No. 13394
P. O. Address Sullivan 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, fact should be so stated above.