

FILED NOV 17 1945

Registration District No. _____

Primary Registration District No. 4193

Registrar's No. 23

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

1. PLACE OF DEATH:

(a) County Gasconade
 (b) City or town Hermann
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
Workman Hospital
(If not in hospital or institution, write street number or location) 1945
 (d) Length of stay: In hospital or institution Since Oct 2nd
(Specify whether)
 In this community 15 years
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Gasconade
 (c) City or town Rural
(If outside city or town limits, write "RURAL")
 (d) Street No. 7 mi. West of Hermann
(If rural, give location)
 (e) Citizen of foreign country? no (Yes or No)
 If yes, name country _____

3. (a) PRINT FULL NAME FRANK ALBERT EIKERMANN

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

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Esther Eikermann 6. (c) Age of husband or wife if alive 41 years

7. Birth date of deceased Oct 5 1897
(Month) (Day) (Year)

8. AGE: Years 48 Months 0 Days 20 If less than one day
hr. _____ min.

9. Birthplace Pershing Mo 1)
(City, town, or county) (State or foreign country)

10. Usual occupation Farmer

11. Industry or business _____

12. Name Fritz Eikermann

13. Birthplace Bay Missouri
(City, town, or county) (State or foreign country)

14. Maiden name Minnie Leimkuehler

15. Birthplace Mt Sterling Missouri
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Frank Eikermann

(b) Address RFD Hermann, Mo

17. (a) Burial (b) Date thereof 10-28-45
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Hermann City Cemetery

18. (a) Signature of funeral director Hugo H. Blumer

(b) Address Hermann, Mo

19. (a) 10/27/45 (b) [Signature]
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct day 23 -
 year 1945 hour 6 minute 30 M.

21. I hereby certify that I attended the deceased from
Oct 2 - 1945 to Oct 6 - 1945;
 that I last saw him alive on Oct 25 - 1945
 and that death occurred on the date and hour stated above.

Immediate cause of death Circulatory Collapse Duration _____

Due to Hypostatic Pneumonia

Due to Operation appendicitis
Oct 3rd 1945

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

PHYSICIAN

Major findings:
 Of operations Ruptured appendix
 Of autopsy ✓
 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 Howard Workman (M. D. or other) _____
 Address Hermann Mo Date signed 10-27-45

1669

RECEIVED

District Health Officer No. 9

District File Number.....

Date Filed.....

11-15-45

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.....

Hugo St. Blumer
.....
Licensed Embalmer No..... 3160

P. O. Address..... Hermann, 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.