No. 2
2-43
5-17-39
X35697

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED FEB 10 1947

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

728

State File No.

Registration District No. 115 Primary Registration District No. 5433 Registrar's No.

1. PLACE OF DEATH:

(a) County Franklin

(b) City or town Union Rural
(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 78
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Franklin

(c) City or town Union R. R.
(If outside city or town limits, write "RURAL")

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

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

If yes, name country

3. (a) PRINT FULL NAME Johann Friedrich Kasmann

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 Widowed

6. (b) Name of husband or wife

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

7. Birth date of deceased February (Month) 27th (Day) 1868 (Year)

8. AGE:

Years	Months	Days	If less than one day
78	10	29	hr. min.

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

10. Usual occupation Retired Farmer

11. Industry or business

FATHER
12. Name Fritz Kasmann
13. Birthplace (City, town, or county) Germany (State or foreign country)

MOTHER
14. Maiden name Louisa Vedder
15. Birthplace (City, town, or county) Germany (State or foreign country)

16. (a) Informant Frank Kasmann
(b) Address Union Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/29/1947 (Month) (Day) (Year)
(c) Place: burial or cremation St. John Mantles

18. (a) Signature of funeral director E. F. Oltmann
(b) Address Union Mo.

19. (a) Jan 29 '47 (Date received local registrar) (b) J. T. Cooper (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 26th day January year 1947 hour 6 minute 10 a. M.

21. I hereby certify that I attended the deceased from 1-10, 1946, to 1-46, 1947; that I last saw him alive on 1-17, 1947; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Apoplexy	5 min
Due to Hypertension	5 yrs
Due to Arteriosclerotic Cardiovascular Disease	10 yrs
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations
Of autopsy

93D

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 R. G. Strehlmann (M. D. or other) M.D.

Address Union Mo. Date signed 1-18-47

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 9
District File Number
Date Filed 2-8-47

DEC 27 1950

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. F. Oltmann

Licensed Embalmer No. 1686

P. O. Address Union 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.

S. No. 2B
M—3-45
X43880

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. Tet

Registration District No. 115 Primary Registration District No. 5433 Registrar's No.

1. PLACE OF DEATH:

(a) County Franklin

(b) City or town Rural
(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 (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

3. (a) PRINT FULL NAME Johann F. Kasmann

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 Wid

6. (b) Name of husband or wife

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

7. Birth date of deceased Feb (Month) 27 (Day) 1868 (Year)

8. AGE: Years 78 Months 10 Days 29 If less than one day hr. min.

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

10. Usual occupation

11. Industry or business

FATHER
12. Name
13. Birthplace (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name
15. Birthplace (City, town, or county) (State or foreign country)

16. (a) Informant
(b) Address

17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)
(c) Place: burial or cremation

18. (a) Signature of funeral director
(b) Address

19. (a) Jan 28-1947 (Date received local registrar) (b) F. T. Cooper CFE (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan day 26
year 1947 hour minute M.

21. I hereby certify that I attended the deceased from
, 19, to , 19;
that I last saw h alive on , 19;
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death	
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

SUPPLEMENTARY

S-728