

FILED JAN 21 1948

Registration District No.

Primary Registration District No. 6047

Registrar's No.

1. PLACE OF DEATH:

(a) County St Charles
(b) City or town Foristell Mo. Rural
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Quivora
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution. 44 yr (Specify whether years, months or days)

3. (a) PRINT FULL NAME Joseph Aimmlein

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 ✓
6. (b) Name of husband or wife. CARRIE Aimmlein 6. (c) Age of husband or wife if alive 78 years
7. Birth date of deceased Aug 8 1866 (Month) (Day) (Year)

8. AGE: Years 81 Months 5 Days - If less than one day hr. min.

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

10. Usual occupation FARMER

11. Industry or business Joseph Aimmlein

12. Name Joseph Aimmlein
13. Birthplace Germany (City, town, or county) (State or foreign country)
14. Maiden name Magdalena Jung
15. Birthplace Germany (City, town, or county) (State or foreign country)

16. (a) Informant Franklin Aimmlein
(b) Address Foristell MO

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-11-1948 (Month) (Day) (Year)

(c) Place: burial or cremation Linn Cemetery

18. (a) Signature of funeral director Heitz
(b) Address 1-14-48

19. (a) 1-14-48 (Date received local registrar) (b) Magdalena Jung (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State MO (b) County St Charles
(c) City or town Foristell Rural
(If outside city or town limits, write "RURAL")
(d) Street No. (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan day 8 year 1948 hour 3:00 minute P. M.

21. I hereby certify that I attended the deceased from June 47 to Jan 48
that I last saw him alive on Jan 3 1948
and that death occurred on the date and hour stated above.

Immediate cause of death Myocardial Regeneration Duration

Due to.
Due to.

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

Major findings: Of operations 978
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 R. C. McMurphy (M. D. or other) MD
Address W. C. McMurphy, MO Date signed 1/9/48

RECEIVED
District Health Officer No. 9,
District File Number
Date Filed 1/23/48

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 T. E. Pitman

Licensed Embalmer No. 2711

P. O. Address Westzville 110

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.