

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

1. PLACE OF DEATH:

(a) County Cole

(b) City or town Russellville Mo  
(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 \_\_\_\_\_ (Specify whether years, months or days)

In this community \_\_\_\_\_ (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Cole

(c) City or town Russellville Mo Moreau Jwp  
(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 NAME Le Roy Kaesling  
FULL NAME

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 25 1948  
year \_\_\_\_\_ hour 3:50 pm minute \_\_\_\_\_ M.

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced 0

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

7. Birth date of deceased: Lohman Mo  
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from birth March 25 1948, to March 25 1948 that I last saw him alive on March 25 1948 and that death occurred on the date and hour stated above.

Immediate cause of death Atelectasis Duration \_\_\_\_\_

Due to Fetal weakness  
premature birth

Due to \_\_\_\_\_

Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_

8. AGE: Years Months Days If less than one day  
Infant hr 20 min.

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

10. Usual occupation \_\_\_\_\_

Major findings: Of operations \_\_\_\_\_ Of autopsy \_\_\_\_\_

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

MOTHER FATHER

11. Industry or business \_\_\_\_\_

12. Name Johann Kaesling

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

14. Maiden name Leona Weber

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

16. (a) Informant Mrs Leona Kaesling (b) Address Lohman Mo

17. (a) \_\_\_\_\_ (b) Date thereof \_\_\_\_\_ (Month) (Day) (Year)  
(Burial, cremation, or removal)

(c) Place: burial or cremation Lohman Mo

18. (a) Signature of funeral director W. N. Schuber  
(b) Address Russellville Mo

19. (a) Mar 26 (b) Mrs Minnie Pittman  
(Date received local registrar) (Registrar's signature)

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 W. L. Leslie M.D. (M. D. or other) \_\_\_\_\_  
Address Russellville Mo Date signed March 26 48

RECEIVED  
District Health Officer No. 9,  
District File Number  
Date Filed 3/21/48

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.....  
*not embalmed*....., Registered Apprentice No.....  
working under my personal supervision.

Signed.....

Licensed Embalmer No.....

P. O. Address.....

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.