

No. 2
12-45
17-39
1X47070

FILED OCT 26 1947

Registration District No. 2

Primary Registration District No. 3058

Registrar's No. 178

1. PLACE OF DEATH:

(a) County St. Charles

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

(c) Name of hospital or institution: St. Joseph's Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 6 Months
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St. Charles 92

(c) City or town St. Charles 7
(If outside city or town limits, write "RURAL")

(d) Street No. 223 N. 3rd. Street 3
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No) 0
If yes, name country _____

3. (a) PRINT FULL NAME Frank F. Ahmann

3. (b) If veteran, name war None

3. (c) Social Security No. None

4. Sex Male 0

5. Color or race White

6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Ernestine Rauch

6. (c) Age of husband or wife if alive 75 years

7. Birth date of deceased: February 6, 1868
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day

79 7 24 hr. min.

9. Birthplace: Marthasville Missouri 6
(City, town, or county) (State or foreign country)

10. Usual occupation: Merchant

11. Industry or business _____

MOTHER FATHER

12. Name: Frederick J. Ahmann

13. Birthplace: Marthasville Missouri 0
(City, town, or county) (State or foreign country)

14. Maiden name: Caroline Schuster

15. Birthplace: Marthasville Missouri 1
(City, town, or county) (State or foreign country)

16. (a) Informant: Francis Ahmann

(b) Address: 223 N. 3rd. Str., St. Charles, Mo.

17. (a) Burial (b) Date thereof: Oct. 2, 1947
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation: St. Johns Cemetery

18. (a) Signature of funeral director: Halkenau-Baue

(b) Address: 326 N. 6th. Str., St. Charles, Mo.

19. (a) 10-13-47 (b) Jennie Hamilton
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept. day 30
year 1947 hour 4 minute 45 P.M.

21. I hereby certify that I attended the deceased from Jan 10, 1946, to Sept 30, 1947,
that I last saw him alive on Sept 30, 1947
and that death occurred on the date and hour stated above.

Immediate cause of death: Carcinoma of prostate 2 yrs
Duration

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? _____

While at work? _____ (Specify type of place)

(e) Means of injury 0

23. Signature: J. J. Schuler (M. D. or other) _____
Address: St. Charles, Mo. Date signed: 10-2-47

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

RECEIVED
District Health Officer No. 9,
District File Number
OCT 18 1947
Date Filed

OCT 19 1956

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..... *Arthur C. Bane*.....
Licensed Embalmer No. *2111*
P. O. Address..... *St Charles 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.

Registration District No. 310

Primary Registration District No. 3058

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

1. PLACE OF DEATH:

(a) County St Charles
(b) City or town St Charles
(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

3. (a) PRINT FULL NAME Frank F. Whman

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 _____

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

7. Birth date of deceased Feb. 6 (Month) (Day) (Year)

8. AGE: Years 79 Months _____ Days _____ (If less than one day, hr. _____ min. _____)

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

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER

12. Name _____

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

14. Maiden name _____

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

16. (a) Informant _____

(b) Address _____

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

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) 10/13/47 (b) Travis Hunter (Date received local registrar) (Registrar's signature)

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 _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month _____ 30
year 1947 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ to _____, 19____; that I last saw him alive on _____, 19____; and that death occurred on the date and hour stated above.
Immediate cause of death _____

Duration

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 _____

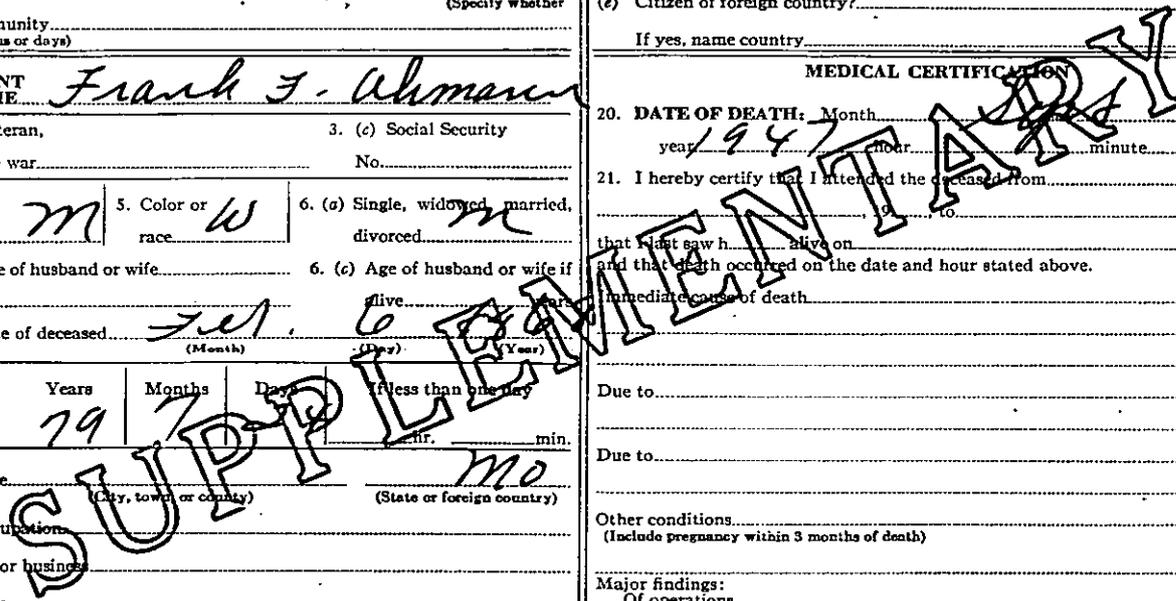
(c) Where did injury occur? _____ (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work? _____ (Specify type of place) (e) Means of injury _____

23. Signature _____ (M. D. or other)

Address _____ Date signed _____



S-35397