

Registration District No. 73

Primary Registration District No. 3.2.01-5118

Registrar's No. 92

1. PLACE OF DEATH:  
 (a) County Boone  
 (b) City or town Rural Route 6, Columbia, Mo.  
(If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution: P  
(If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution: \_\_\_\_\_  
(Specify whether)  
 In this community: 25 Years  
years, months or days

2. USUAL RESIDENCE OF DECEASED: 10  
 (a) State Missouri (b) County Boone  
 (c) City or town Rural Route 6, Columbia, Mo.  
(If outside city or town limits, write "RURAL")  
 (d) Street No. Rural Route 6  
(If rural, give location)  
 (e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
 If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME KARL HENRY GUNDELFINGER  
 3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. 190-07-1713

MEDICAL CERTIFICATION  
 20. DATE OF DEATH: Month May day 25  
 year 1942 hour 11:30 minute A. M.

4. Sex Male 5. Color or race White  
 6. (a) Single, widowed, married, divorced Married  
 6. (b) Name of husband or wife Willie 6. (c) Age of husband or wife if alive 38 years  
 7. Birth date of deceased: 1 23 1898  
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from \_\_\_\_\_ 19 \_\_\_\_\_ to \_\_\_\_\_ 19 \_\_\_\_\_  
 that I last saw him alive on \_\_\_\_\_ 19 \_\_\_\_\_  
 and that death occurred on the date and hour stated above.

8. AGE: Years 44 Months 4 Days 2 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

Immediate cause of death Self Inflicted  
 Due to \_\_\_\_\_  
 Due to \_\_\_\_\_  
 Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_

9. Birthplace Jefferson City, Mo. (City, town, or county) (State or foreign country) 0  
 10. Usual occupation Bookkeeper

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

11. Industry or business \_\_\_\_\_  
 12. Name Daniel Gundelfinger  
 13. Birthplace Germany (City, town, or county) (State or foreign country) 4  
 14. Maiden name Bertha Koessen  
 15. Birthplace Missouri (City, town, or county) (State or foreign country) 0

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

16. (a) Informant Mrs. Karl H. Gundelfinger  
 (b) Address Route 6, Columbia, Mo.  
 17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 5-27-42 (Month) (Day) (Year)  
 (c) Place: burial or cremation Columbia Cemetery  
Parker Funeral Service  
 18. (a) Signature of funeral director \_\_\_\_\_  
 (b) Address Columbia, Missouri  
 19. (a) 5-27-42 (Date received local registrar) (b) Cedric H. Barber (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 3  
 23. Signature Margie McLean (Dr. or other) \_\_\_\_\_  
 Address Columbia Mo. Date signed 5/27

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

1000

1.250

Phone 8688-

APR 1 1971

**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

*M. V. McReynolds*

Licensed Embalmer No.

*3893*

P. O. Address

*Columbia*

**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.**

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. **17263**

Registration District No. **73**

Primary Registration District No. **92**

Registrar's No.

1. PLACE OF DEATH: **Boone Rural**

(a) County.....

(b) City or town.....  
(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 **Karl H. Gundelfinger**

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 **m**

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

7. Birth date of deceased **Jan 23 1893**  
(Month) (Day) (Year)

8. AGE: Years **44** Months **4** Days **3** (If less than one day, in min.)

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

10. Usual occupation.....

11. Industry of business.....

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) (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) (Date received local registrar) (b) (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 **May** day..... year **1942** hour..... minute..... M.

21. I hereby certify that I attended the deceased from....., 19....., and that death occurred on the date and hour stated above.

Immediate cause of death **Gun shot wound in head.**

Due to.....

Due to **Self Infliction**

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

Major findings:  
Of operations..... **164e**

Of autopsy.....

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) **Suicide**

(b) Date of occurrence.....

(c) Where did injury occur? **at home Boone Mo**  
(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) (c) Means of injury

23. Signature **Marion Wilson** **Coroner**  
Address **Columbia Mo** Date signed.....

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

SUPPLEMENTARY

MOTHER FATHER

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

37017 150E

S-17363

11/11/50

11/11/50

11/11/50