

Registration District No. 146

Primary Registration District No. 3026

1. PLACE OF DEATH:

(a) County **JACKSON**
 (b) City or town **INDEPENDENCE**
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
RESIDENCE 210 N. UNION
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution.....
 In this community **22 YEARS** (Specify whether
 years, months or days)

3. (a) PRINT **JOHN F. FASSNACHT**
FULL NAME

3. (b) If veteran, **NO.** name war.....
 3. (c) Social Security No. **490-09-2199**

4. Sex **MALE** 5. Color or race **WHITE**
 6. (a) Single, widowed, married, divorced **MARRIED**
 6. (b) Name of husband or wife **NORA**
 6. (c) Age of husband or wife if alive **68** years
 7. Birth date of deceased **JAN. 27 1872**
 (Month) (Day) (Year)

8. AGE: Years **71** Months **6** Days **0**
 If less than one day hr. min.

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

10. Usual occupation **RETIRED; MAILING CLERK**11. Industry or business **HERALD PUBLISHING HOUSE**

MOTHER FATHER { 12. Name **LEWIS FASSNACHT**
 13. Birthplace **NO RECORD** 9
 (City, town, or county) (State or foreign country)
 14. Maiden name **ELLA MOSS**
 15. Birthplace **NO RECORD** 9
 (City, town, or county) (State or foreign country)

16. (a) Informant **MRS. NORA FASSNACHT.**(b) Address **210 N. UNION**

17. (a) **BURIAL** (b) Date thereof **7 - 30 - 43**
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **MOUND GROVE CEMETERY**18. (a) Signature of funeral director **Henry W. Stahl**(b) Address **815 W. MAPLE AVE.**

19. (a) **7-29-43** (b) **James Moss**
 (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **MISSOURI** (b) County **JACKSON**
 (c) City or town **INDEPENDENCE**
 (If outside city or town limits, write "RURAL")
 (d) Street No. **210 N. UNION**
 (If rural, give location)
 (e) Citizen of foreign country? **NO.** (Yes or No)
 If yes, name country.....

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **7** day **27**
 year **1943** hour **9** minute **15 P** M.

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

Immediate cause of death **Eranni** Duration
Eranni

Due to.....

Due to.....

Other conditions.....
 (Include pregnancy within 3 months of death) **93d**

Major findings:
 Of operations.....

Of autopsy **Section**

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 **Eranni** 3 7/29/43
 Address **Ram** Date signed

SEP 2 1943

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.....

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.