

FILED NOV 10 1944  
Registration District No. 082

Primary Registration District No. 4228

Registrar's No. 34

1. PLACE OF DEATH:

(a) County HOWARD  
(b) City or town RURAL  
(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) 1

(d) Length of stay: In hospital or institution \_\_\_\_\_  
In this community 19 yrs 6 mos 4 days (Specify whether years, months or days)

3. (a) PRINT FULL NAME LINUS FUENNELER

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 single

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

7. Birth date of deceased APR. 9 1925  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
19 6 4 hr. min.

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

10. Usual occupation Farmer

11. Industry or business his fathers farm

12. Name Linus Fuenneler

13. Birthplace Chariton County MO  
(City, town, or county) (State or foreign country)

14. Maiden name Louise Abbott Fuenneler

15. Birthplace Warren County MO  
(City, town, or county) (State or foreign country)

16. (a) Informant John Fuenneler

(b) Address Glasgow MO 64504

17. (a) Burial (b) Date thereof 10/16/44  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Glasgow MO

18. (a) Signature of funeral director Arthur Fremont

(b) Address Glasgow MO

19. (a) 10/16/44 (b) [Signature]  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri County Howard  
(c) City or town 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 Oct day 13  
year 1944 hour 8:15 minute A. M.

21. I hereby certify that I attended the deceased from 3 - 1 1944 to 10 - 13 1944  
that I last saw him alive on 10 - 13 1944  
and that death occurred on the date and hour stated above.

Immediate cause of death Valvula  
Heart Disease Duration \_\_\_\_\_

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

Due to 92d

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 \_\_\_\_\_

Signature [Signature] (M. D. or other) \_\_\_\_\_

Address Glasgow Date signed 10/15/44

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

005

RECEIVED

District Health Officer No. 8,

District File Number \_\_\_\_\_

Date Filed 1-9-47

MO. I A  
-FEB. REC. 1951

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 J. Walker Audsley  
Licensed Embalmer No. 3336  
P. O. Address Glasgow 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. *82*

Primary Registration District No. *574*

Registrar's No. *34*

1. PLACE OF DEATH:

(a) County *Howard*

(b) City or town *Rural Chariton Twp*  
(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 *Linus F. Fummeles*

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 *s*

6. (b) Name of husband or wife \_\_\_\_\_

6. (c) Age of husband or wife if alive \_\_\_\_\_ year

7. Birth date of deceased *April 9*  
(Month) (Day) (Year)

8. AGE: Years *14* Months *6* Days \_\_\_\_\_ If less than one day \_\_\_\_\_ min.

9. Birthplace \_\_\_\_\_ (City, town, or county) (State or foreign country) *mo.*

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

11. Industry or 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) \_\_\_\_\_ (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) \_\_\_\_\_ (b) \_\_\_\_\_  
(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 *April* Day *9* Year *1944* Minute \_\_\_\_\_ M.

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

Immediate cause of death \_\_\_\_\_

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

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

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

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

Of autopsy \_\_\_\_\_

Duration \_\_\_\_\_

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 \_\_\_\_\_

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

SUPPLEMENTARY

MOTHER FATHER

34358