

**FILED FEB 4 1946**

Registration District No. 114

Primary Registration District No. 4186

Registrar's No. 53

1. PLACE OF DEATH: **Franklin**  
 (a) County **Sullivan**  
 (b) City or town **Sullivan**  
(If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution: **North Side Hospital**  
(If not in hospital or institution, write street number or location)  
 (d) Length of stay: **24 HOURS**  
In hospital or institution (Specify whether)  
 In this community **20 Years**  
(years, months or days)

2. USUAL RESIDENCE OF DECEASED:  
 (a) State **Missouri** (b) County **Franklin**  
 (c) City or town **Sullivan, Mo.**  
(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 \_\_\_\_\_

3. (a) PRINT FULL NAME **Charles Henry Schuenemann**  
 3. (b) If veteran, name war **yes War I.** 3. (c) Social Security No. \_\_\_\_\_

MEDICAL CERTIFICATION  
 20. DATE OF DEATH: Month **Jan.** day **17**  
 year **1946** hour **3** minute **30** A.M.

4. Sex **M** 5. Color or race **W** 6. (a) Single, widowed, married, divorced **Single**  
 6. (b) Name of husband or wife **None** 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
 7. Birth date of deceased **Oct. 11th. 1886**  
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from **Jan 3 '46 to Jan 17 '46**  
 that I last saw him alive on **Jan 17 '46**  
 and that death occurred on the date and hour stated above.

8. AGE: **59** Years **3** Months **6** Days If less than one day  
hr. min.

Immediate cause of death **Pulmonary rupture** Duration **30 hours**

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

Due to **Bronchial asthma** **grass**

10. Usual occupation **Filling Station Operator**

Due to **upper respiratory infection** **14th**

11. Industry or business **Gas & Oil Salesman**

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

12. Name **Fred L. Schuenemann**

Major findings: **112**  
 Of operations \_\_\_\_\_  
 Of autopsy \_\_\_\_\_

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

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

14. Maiden name **Rhoda Eva Knost**

15. Birthplace **Clay City, Ill.**  
(City, town, or county) (State or foreign country)

16. (a) Informant **Eleanor Schuenemann**  
 (b) Address **5147 Vernon Ave. St. Louis**

17. (a) **Burial** (b) Date thereof **1-19-1946**  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **St. Louis, Mo.**  
 18. (a) Signature of funeral director **J. T. Williams**  
 (b) Address **Sullivan, Mo.**

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?  
 \_\_\_\_\_

23. Signature **Dr. Proctor** (M. D. or other) \_\_\_\_\_  
 Address **Sullivan, Mo.** Date signed **1-18-46**

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

559

RECEIVED  
District Health Officer No. 9,  
District File Number \_\_\_\_\_  
Date Filed 2-2-46

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. T. Williams  
Licensed Embalmer No. 427  
P. O. Address Sullivan, 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.