

**MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH**

6732
Do not use this space.

FILED MAR 16 1940

1. PLACE OF DEATH

(a) County Henry Registration District No. 347
 (b) Township Blairstown Primary Registration District No. 7205
 (c) City Blairstown (d) Street No. _____
 (If death occurred in Hospital or Institution, write its name instead of street and number)
 (e) Length of residence in city or town where death occurred _____ yrs. mos. ds. (f) How long in U.S., if of foreign birth? _____ yrs. mos. ds.

2. PRINT FULL NAME

John Joseph Fellhauer
 (a) Residence, No. Blairstown Mo St. (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED Married
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Mary D Fellhauer
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) July 17 1870
 7. AGE YEARS 69 MONTHS 6 DAY 19 If LESS than 1 day, _____ hrs. or _____ min.

OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Mail Carrier
 9. Industry or business in which work was done, as saw mill, bank, etc. Government
 10. Date deceased last worked at this occupation (month and year) August 1935 11. Total time (years) spent in this occupation 17

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Blairstown Mo

FATHER 13. NAME John Baptist Fellhauer

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Illinois

MOTHER 15. MAIDEN NAME Lena Mollett

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Penn.

17. INFORMANT (ADDRESS) Merle Fellhauer Walker

18. BURIAL, CREMATION, OR REMOVAL PLACE Chelkouse mo DATE 2-7-1940

19. FUNERAL DIRECTOR (NAME) (ADDRESS) O.R. Leach

20. FILED 2-19 30 Blairstown Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) February 5 1940
 22. I HEREBY CERTIFY, That I attended deceased from February 4, 1940, to February 5, 1940
 I last saw him alive on February 5, 1940. Death is said to have occurred on the date stated above, at 3:30 P.M.
 The principal cause of death and related causes of importance were as follows:

cerebral thrombosis

Date of onset 2/4/40

Other contributory causes of importance:

Bronchial Asthma

Name of operation none Date of _____
 What test confirmed diagnosis? _____ Was there an autopsy? no

23. If death was due to external causes (violence), fill in also the following:
 Accident, suicide, or homicide? _____ Date of injury _____, 19____
 Where did injury occur? _____ (Specify city or town, county, and State)
 Specify whether injury occurred in industry, in home, or in public place.

Manner of injury _____
 Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased? _____
 If so, specify _____ (Signed) R. J. Powell D.O.
 (Address) Blairstown, Missouri

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

FORM-12-2-36 1 X14228

RECEIVED
District Health Officer No. 7,
District File Number 3-40-385
Date Filed 3-6-40

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 O. K. Cook

Licensed Embalmer No. 2708

P. O. Address Chilhouse 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, above space should be left blank.