

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

Do not use this space.

*Dr. Feller*  
36524

**1. PLACE OF DEATH**

County Greene Registration District No. 318  
Township \_\_\_\_\_ Primary Registration District No. 2001  
City Springfield 824 N. Jefferson

File No. \_\_\_\_\_  
Registered No. 739  
St. \_\_\_\_\_ Ward \_\_\_\_\_

**2. FULL NAME**

(a) Residence. No. 824 N. Jeff St. \_\_\_\_\_ Ward. \_\_\_\_\_  
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. da. How long in U.S., if of foreign birth? yrs. mos. da.

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX <u>m</u>	4. COLOR OR RACE <u>wh</u>	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) <u>married</u>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND or (or) WIFE or <u>Eva Powers</u>		
6. DATE OF BIRTH (MONTH, DAY AND YEAR) <u>Mar 4-1863</u>		
7. AGE YEARS <u>64</u>	MONTHS <u>9</u>	DAYS <u>1</u>
IF LESS than 1 day, _____ hrs. or _____ min.		

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work farmer

(b) General nature of industry, business, or establishment in which employed (or employer) Retired

(c) Name of employer \_\_\_\_\_

9. BIRTHPLACE (CITY OR TOWN) Washington  
(STATE OR COUNTRY) Va

10. NAME OF FATHER Unknown

11. BIRTHPLACE OF FATHER (CITY OR TOWN) Unknown  
(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER Unknown

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Unknown  
(STATE OR COUNTRY)

14. INFORMANT Mrs. Eva Powers  
(Address) Springfield Mo

15. FILED 12/6 1927 Oct 1st Mrs  
REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) 12/5 1927

17. I HEREBY CERTIFY, That I attended deceased from 11-18-1927 to 12-5-1927 that I last saw him alive on 12-25-1927, and that death occurred, on the date stated above, at 403 \_\_\_\_\_.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:  
Apoplexy  
8 1/2 (duration) yrs. mos. 2 da.

CONTRIBUTORY Chronic Prostatitis  
(SECONDARY) (duration) yrs. mos. da.

18. WHERE WAS DISEASE CONTRACTED Home  
IF NOT AT PLACE OF CONTRACTED \_\_\_\_\_

19. DID AN OPERATION PRECEDE DEATH? \_\_\_\_\_ DATE OF \_\_\_\_\_  
WAS THERE AN AUTOPSY? \_\_\_\_\_

WHAT TEST CONFIRMED DIAGNOSIS?  
(Signed) C. E. Feller, M. D.  
12-6-19 (Address) Springfield Mo

\*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION OR REMOVAL Calool Mo DATE OF BURIAL 12/6 1927

20. UNDERTAKER Gaylord Elliott ADDRESS Calool Mo.

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.

PERMANENT RECORD

1928

