

REC'D JUL 17 1938

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

Do not use this space.

1. PLACE OF DEATH *Saline* 1
County *Saline* Registration District No. *796*
Township _____ Primary Registration District No. *3038*
City *Marshall* (No. _____) St. _____ Ward _____

2. FULL NAME *Maritta Feagans* 252
(a) Residence, No. _____ 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. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

23041

File No. _____
Registered No. *104*

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX *Female*
4. COLOR OR RACE *White*
5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) *Widow*
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF *William Feagans*
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) *December 10 1849*
7. AGE YEARS *88* MONTHS *6* DAYS *17*
If LESS than 1 day, _____ hra. or _____ min.

21. DATE OF DEATH (MONTH, DAY, AND YEAR) *June 27 1938*
I HEREBY CERTIFY that I attended deceased from *Jan 20 1938* to *June 27 1938*
I last saw her alive on *June 27 1938* Death is said to have occurred on the date stated above, at *2 P.M.*
The principal cause of death and related causes of importance were as follows:

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. *House wife*
9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. _____
10. Date deceased last worked at this occupation (month and year) _____
11. Total time (years) spent in this occupation _____

Airborne
Liver
124 181
Date of onset *1936*

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Gasconade Co. Mo.*
13. NAME *unknown*
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) _____
15. MAIDEN NAME *unknown*
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) _____

Other contributory causes of importance: *Chronic Myocarditis*
Name of operation *None* Date of _____
What test confirmed diagnosis? *Clinical* Was there an autopsy? *None*

17. INFORMANT *Mrs. Albert Heil*
(ADDRESS) _____
18. BURIAL, CREMATION, OR REMOVAL PLACE *Gasconade* DATE *6-27-38*
19. UNDERTAKER *Clyde Morten*
(ADDRESS) *Springfield Mo*
20. FILED *6-27-38* *Mary Kent* Deputy Registrar

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? *no* 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? *no*
If so, specify _____
(Signed) *W. H. ...* M. D.
(Address) *712 ...*

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.

1938

