

LEG'D FEB 9 1939

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

1693
Do not use this space.

1. PLACE OF DEATH

(a) County Buchanan Registration District No. 85
 (b) Township WASHINGTON Primary Registration District No. 1001
 (c) City ST JOSEPH (d) Street No. 1523 JULES St.
 (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

JACOB FELTENSTEIN
 (a) Residence, No. 1523 JULES St. (If nonresident, give city or town and State)
 (Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX MALE 4. COLOR/OR RACE WHITE 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED, (write the word) WIDOWED
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF ROSE FELTENSTEIN
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) JUNE 11th 1859
 7. AGE YEARS 79 MONTHS 7 DAYS 17 If LESS than 1 day, hrs. or min.
 OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. RETIRED
 9. Industry or business in which work was done, as saw mill, bank, etc. MERCHANT
 10. Date deceased last worked at this occupation (month and year) 11. Total time (years) spent in this occupation

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) JAN 28, 1937

22. I HEREBY CERTIFY, That I attended deceased from July 31, 1937, to Jan 28, 1939.
 I last saw him alive on Jan 28, 1939. Death is said to have occurred on the date stated above, at 11:55 P. m.

The principal cause of death and related causes of importance were as follows:

Chronic Pulmonary Date of onset 1-28-37

Other contributory causes of importance:

Chronic Rheumatic Arteriosclerosis

Name of operation _____ Date of _____
 What test confirmed diagnosis clinical 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? no
 If so, specify _____ (Signed) J. V. Repair, M. D.
 _____ (Address) St Joseph Mo.

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Russia

FATHER 13. NAME JOEL FELTENSTEIN

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

MOTHER 15. MAIDEN NAME SHIFFRA GOLDMAN

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

17. INFORMANT (ADDRESS) Arch FELTENSTEIN

18. BURIAL, CREMATION, OR REMOVAL PLACE MARE SHOLEM DATE JAN 30th 39

19. FUNERAL DIRECTOR (NAME) (ADDRESS) FLEEMAN & SON, INC.
1946 CALHOUN St Joseph Mo

20. FILED F-30 1939 J. V. Repair Local Registrar.

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.

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 John E. Rupp

Licensed Embalmer No. 3986

P. O. Address St Joseph, 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.