S. No. 2
—11-10-39
. 5-17-39
P I X21492

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

1002

State File No. 34347

NOV 12 1940

Registration District No. 399

Primary Registration District No.

Registrar's No. 3863

1. PLACE OF DEATH:

(a) County: Jackson

(b) City or town: Kansas City
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: 5609 E. 27th. 2
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution (Specify whether years, months or days)

In this community: 2 Yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State: Mo. (b) County: Jackson

(c) City or town: Kansas City
(If outside city or town limits, write "RURAL")
0

(d) Street No.: 5609 E. 27th.
(If rural, give location)

(e) If foreign born, how long in U. S. A.? ____ years.

3. (a) PRINT FULL NAME: Margaret Ann Feakes

3. (b) If veteran, name war: No.

3. (c) Social Security No.: No.

4. Sex: Fe.

5. Color or race: Wh.

6. (a) Single, widowed, married, divorced: Widow

6. (b) Name of husband or wife: Wm. Feakes

6. (c) Age of husband or wife if alive ____ years

7. Birth date of deceased: June 11 (Month) 26 (Day) 1842 (Year)

8. AGE: Years 98 | Months 3 | Days 10 | If less than one day ____ hr. ____ min.

9. Birthplace: Rochelle (City, town, or county) Ill. (State or foreign country) 1

10. Usual occupation: Home 4

11. Industry or business: 7

FATHER
12. Name: Lewis James 1
13. Birthplace: Unknown (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name: Campbell
15. Birthplace: Unknown (City, town, or county) (State or foreign country)

16. (a) Informant: Minnie C. Shattuck
(b) Address: 5609 E 27th. K.C.Mo.

17. (a) Removal (Burial, cremation, or removal) (b) Date thereof: Oct. 6 -40 (Month) (Day) (Year)
(c) Place: burial or cremation: Grand Junction Iowa

18. (a) Signature of funeral director: Eylar Funeral Home
(b) Address: 1800 Linwood K.C.Mo.

19. (a) 10-6-40 (Date received local registrar) (b) M. M. Browne (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct day 6 year 1940 hour 5. minute 20 A.M.

21. I hereby certify that I attended the deceased from Sep 2, 1940, to Oct. 5, 1940, that I last saw him alive on Oct 5, 1940 and that death occurred on the date and hour stated above.

Immediate cause of death: Cerebral thrombosis — Duration 3 days

Due to: arteriosclerosis — 5 yrs.

Due to: ____

Other conditions: arteriosclerosis
(Include pregnancy within 3 months of death)

Major findings:
Of operations: —
Of autopsy: —

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

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? ____
While at work? ____ (Specify type of place) (e) Means of injury: —

23. Signature: Otokar Hofmann (M. D. or other)
Address: 900 Rialto Bldg. Date signed: 10/6/40

(Licensed Embalmer's Statement on Reverse Side)

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 Chase Fields

Licensed Embalmer No. 2644

P. O. Address 1800 Linwood

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.