

No. 2
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED NOV 17 1947

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **37119**
Registration District No. **42**
Primary Registration District No. **1000**
Registrar's No. **1340**

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

1. PLACE OF DEATH:
(a) County Buchanan
(b) City or town St. Joseph
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
State Hospital No. 2
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 2 yrs. 2 mos. 20 days
(Specify whether years, months or days)

3. (a) PRINT FULL NAME LYLE B. FELT'S.
(b) If veteran, name war UNO
(c) Social Security No. UNO

4. Sex Male Color or race White
5. Color or race White
6. (a) Single, widowed, married, divorced Separated
6. (b) Name of husband or wife Dorothy Felt's
6. (c) Age of husband or wife if alive 42 years
7. Birth date of deceased 2-8-1905
(Month) (Day) (Year)

8. AGE: Years 44 Months 9 Days 0
If less than one day hr. min.

9. Birthplace Caldwell Mo. Missouri
(City, town, or county) (State or foreign country)

10. Usual occupation Farmer

11. Industry or business Agriculture

12. Name Lyle Felt's

13. Birthplace unknown Missouri
(City, town, or county) (State or foreign country)

14. Maiden name Ola Sparks

15. Birthplace unknown Missouri
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Charles Barnes

(b) Address Camden, Missouri

17. (a) Burial (b) Date thereof 11-19-1947
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Hamilton, Mo

18. (a) Signature of funeral director Cramer Clark

(b) Address Kingston, Mo

19. (a) 11-13-47 (b) N. L. Jenkins
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Caldwell
(c) City or town Rural
(If outside city or town limits, write "RURAL")
(d) Street No. 11
(If rural, give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country U

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month 11 day 8
year 1947 hour 11 minute 15 A M.
21. I hereby certify that I attended the deceased from 9-25, 1947 to 11-8-, 1947
that I last saw him alive on 11-8-, 1947
and that death occurred on the date and hour stated above.

Immediate cause of death choked on piece of meat
Due to Meningo-encephalitis
Syphilitic
Due to Psychosis
Other conditions 1954
(Include pregnancy within 3 months of death)

Major findings: Of operations 1954
Of autopsy Palms of meat lodged in trachea and ligation

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) 011
(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 0

23. Signature Forrest Thomas (M. D. over)
Address State Hospital No. 2 Date signed 11-8

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 James Clark

Licensed Embalmer No. 3257

P. O. Address Kingston, 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, fact should be so stated above.