

No. 300
10-47
17-39
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FEDERAL SECURITY AGENCY
National Office of Vital Statistics

MISSOURI DEPARTMENT OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **38097**
10220
Registrar's No.

FILED DEC 8 1948

318

Primary Registration District No. **1003**

Registration District No.

1. PLACE OF DEATH:

(a) County St. Louis
(b) City or town St. Louis
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Jewish Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____
(Specify whether _____)
In this community _____
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St. Louis
(c) City or town St. Louis
(If outside city or town limits, write "RURAL")
(d) Street No. Albany Hotel-4873 Page Blvd.
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME John Raymond Fellers

3. (b) If veteran, name war No 3. (c) Social Security No. 489-09-9451

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Single

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased July 25 1897
(Month) (Day) (Year)

8. AGE: Years 51 Months 3 Days 27 If less than one day hr. _____ min. _____

9. Birthplace Schuline Illinois
(City, town, or county) (State or foreign country)

10. Usual occupation Stationary Engineer

11. Industry or business _____

12. Name Commodore Perry Fellers

13. Birthplace Sparta Illinois
(City, town, or county) (State or foreign country)

14. Maiden name Albina Florence Henderlite

15. Birthplace New Palestine Illinois
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Mayetta Schoepfel
(b) Address Sparta, Illinois

17. (a) Removal (b) Date thereof 11-23-48
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Sparta, Ill.

18. (a) Signature of funeral director Albert H. Hoppe
(b) Address 4700 Washington Blvd.

19. (a) NOV 24 1948 (b) J. B. Pasater
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov. day 22
year 1948 hour 6 minute P M.

21. I hereby certify that I attended the deceased from 11-18, 1948, to 11-22, 1948
that I last saw him alive on 11-22, 1948
and that death occurred on the date and hour stated above.

Immediate cause of death Septal Coronary Infarct Duration 1 day
Due to Subacute Bacterial Endocarditis - strep viridans 2 wks
Due to Rheumatic Heart Disease 30 yrs

Other conditions Chronic Passive Congestion 6 d.
(Include pregnancy within 3 months of death)

Major findings: Of operations _____
Of autopsy as above 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? _____

(Specify type of place) _____
While at work? _____ (c) Means of injury D

23. Signature A. J. Steiner (M. D. or other) MD
Address 634 1/2 Grand St. St. Louis Date signed 11-24

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

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 *Justin W. Dietrich*
Licensed Embalmer No. *4329*
P. O. Address *St. Louis, 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.