

FILED JAN 21 1949

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

234

State File No. ....

 BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 42 PRIMARY REG. DIST. NO. 1000 Registrar's No. 67

1. PLACE OF DEATH a. COUNTY <b>Buchanan</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Buchanan</b>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>St. Joseph, Mo</b>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>St. Joseph, Mo.</b>	
c. LENGTH OF STAY (in this place) <b>8 Days</b>		d. STREET ADDRESS (If rural, give location) <b>627 South 14th St.</b>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>St. Joseph Hospital</b>			

3. NAME OF DECEASED (Type or Print)	a. (First) <b>Olivia</b>	b. (Middle) <b>Marie</b>	c. (Last) <b>Felling</b>	4. DATE OF DEATH (Month) (Day) (Year) <b>Jan. 13 1949</b>
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5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Never Married</b>	8. DATE OF BIRTH <b>April 8, 1885</b>	9. AGE (In years last birthday) <b>63</b>	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Housekeeper</b>	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <b>St. Joseph, Mo.</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
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13a. FATHER'S NAME <b>Theodore Felling</b>	13b. MOTHER'S MAIDEN NAME <b>Minnie Aniser</b>	14. NAME OF HUSBAND OR WIFE <b>None</b>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>	16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <b>None</b>	17. INFORMANT'S SIGNATURE OR NAME <b>Miss Florence Felling</b>	ADDRESS <b>627 So. 14th</b>
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)  *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Myocardial Insufficiency</b>	<b>Generalized Atherosclerosis</b>	<b>10 days</b>
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <b>Diabetes Mellitus</b>		<b>? Years</b> <b>? Years</b>
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
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21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (m.)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
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22. I hereby certify that I attended the deceased from Jan 12, 1949, to Jan 13, 1949, that I last saw the deceased alive on Jan 12, 1949, and that death occurred at 5:00A m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <b>Robert Conrad MD</b>	23b. ADDRESS <b>St. Joseph Mo</b>	23c. DATE SIGNED <b>Jan 13 1949</b>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	24b. DATE <b>1-15-1949</b>	24c. NAME OF CEMETERY OR CREMATORY <b>Mt. Olivet Cemetery</b>	24d. LOCATION (City, town, or county) (State) <b>St. Joseph Mo.</b>
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DATE REC'D BY LOCAL REG. <b>Jan. 17, 1949</b>	REGISTRAR'S SIGNATURE <b>E. C. Jenkins</b>	25. FUNERAL DIRECTOR'S SIGNATURE <b>Herman W. Biederhaden</b>	ADDRESS <b>1802 Lincoln</b>
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(Licensed Embalmer's Statement on Reverse Side)

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

No. 300  
10.4811  
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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 \_\_\_\_\_

working under my personal supervision.

Student .....  
Student Embalmer

Signed *Robert H. Yapple* Student Embalmer No. \_\_\_\_\_

Licensed Embalmer No. *3308*

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, fact should be so stated above.