

FILED JAN 16 1950

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH  
318

1003

State File No. \_\_\_\_\_  
Registrar's No. 25

BIRTH NO. _____		REG. DIST. NO. _____		PRIMARY REG. DIST. NO. _____		Registrar's No. 25		
1. PLACE OF DEATH a. COUNTY _____				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>Missouri</b> b. COUNTY <b>2159</b>				
b. CITY (If outside corporate limits, write RURAL and give town) <b>St. Louis</b>		c. LENGTH OF STAY (In this place) _____		c. CITY (If outside corporate limits, write RURAL and give township) <b>St. Louis</b>				
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>6044 Arsenal St.</b>				d. STREET ADDRESS (If rural, give location) <b>6044 Arsenal St.</b>				
3. NAME OF DECEASED (Type or Print) a. (First) <b>William</b>		b. (Middle) <b>J.</b>		c. (Last) <b>Feder</b>		4. DATE OF DEATH (Month) (Day) (Year) <b>1-1-1950</b>		
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Widower</b>		8. DATE OF BIRTH <b>2-21-1877</b>		
9. AGE (In years last birthday) <b>72</b>		IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 2 HRS. Hours _____ Min. _____				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Elevator Operator</b>			10b. KIND OF BUSINESS OR INDUSTRY _____			11. BIRTHPLACE (State or foreign country) <b>Illinois</b>		
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			13a. FATHER'S NAME <b>John Feder</b>		13b. MOTHER'S MAIDEN NAME <b>Emma Feder</b>		14. NAME OF HUSBAND OR WIFE <b>*****</b>	
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>497-03-9072</b>		17. INFORMANT'S SIGNATURE OR NAME <b>Rolland Feder</b> ADDRESS <b>6044 Arsenal St</b>				
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, asthenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION						
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) _____		ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <b>Paronychia of Pilonus</b>				INTERVAL BETWEEN ONSET AND DEATH <b>about 20</b>		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		DUE TO (c) <b>Pharyngeal Myocarditis</b>				<b>about 1 year</b>		
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
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) <b>930</b>				
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? <b>4 20 1</b>				
22. I hereby certify that I attended the deceased from <b>Jan 12, 1950</b> , to <b>Jan 1, 1950</b> , that I last saw the deceased alive on <b>Jan 1, 1950</b> , and that death occurred at <b>1:00 P.m.</b> , from the causes and on the date stated above.								
23a. SIGNATURE <b>J. B. Hasater</b> (Degree or title) <b>M.D.</b>				23b. ADDRESS <b>3606 Gravois</b>		23c. DATE SIGNED <b>1/3/50</b>		
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		24b. DATE <b>1-4-1950</b>		24c. NAME OF CEMETERY OR CREMATORY <b>Valhalla Cemetery</b>		24d. LOCATION (City, town, or county) (State) <b>Belleville Ill. Ill.</b>		
DATE REC'D BY LOCAL REG. <b>JAN 3 1950</b>		REGISTRAR'S SIGNATURE <b>J. B. Hasater</b>		25. FUNERAL DIRECTOR'S SIGNATURE <b>Ziegenhein Bros</b> ADDRESS <b>6409 Gravois Ave</b>				

Dr. Weinsburg 3606 Gravois Ave  
SI 2959  
WRITE PLAINLY—USING 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 \_\_\_\_\_

Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Student .....

Student Embalmer

Signed

*Robert M. Murray*

Licensed Embalmer No. *3749*

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.