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FILED AUG 24 1954

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

26979  
State File No. ....

BIRTH NO. ... REG. DIST. NO. 140 PRIMARY REG. DIST. NO. 3024 Registrar's No. 63

1. PLACE OF DEATH a. COUNTY <b>Howard</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>Missouri</b> b. COUNTY <b>Howard</b>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>Fayette</b>		c. CITY OR TOWN <b>Fayette</b>	d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. LENGTH OF STAY (in this place) <b>2 hrs</b>		STREET ADDRESS (If rural, give location) <b>306 N. Church St. 045/0</b>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>Lee Hospital</b>			

3. NAME OF DECEASED (Type or Print) a. (First) <b>Benjamin</b> b. (Middle) <b>Tolson</b> c. (Last) <b>Feland</b>			4. DATE OF DEATH (Month) (Day) (Year) <b>Aug. 7, 1954</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Widowed</b>	8. DATE OF BIRTH <b>July 14, 1875</b>		9. AGE (In years last birthday) <b>79</b> IF UNDER 1 YEAR Months <b>0</b> Days <b>23</b> IF UNDER 24 HRS. Hours <b></b> Min. <b></b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Farm</b>	11. BIRTHPLACE (City and State or Foreign Country) <b>Howard Co. Missouri</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>

13a. FATHER'S NAME <b>W. R. Feland</b>		13b. MOTHER'S MAIDEN NAME <b>Mary Harris Barn</b>		14. NAME OF HUSBAND OR WIFE <b>Della Mae Hern</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. <b>None</b>	17. INFORMANT'S SIGNATURE OR NAME ADDRESS <b>Mrs Thomas Hall Fayette, Mo</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 <b>4 hr.</b>
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Cerebral hemorrhage</b>		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <b>hypertensive cardiovascular disease</b> DUE TO (c) <b>none</b>		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <b>none</b>			

19a. DATE OF OPERATION <b>none</b>	19b. MAJOR FINDINGS OF OPERATION <b>4/5 X</b>	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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21a. ACCIDENT SUICIDE HOMICIDE (Specify) <b>Natural</b>	21b. PLACE OF INJURY (Specify in or about home, farm, factory, street, office, etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute) <b>10 P m.</b>	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 8-7, 1954, to 8-7, 1954, that I last saw the deceased alive on 8-7, 1954, and that death occurred at 10 P m., from the causes and on the date stated above.

23a. SIGNATURE <b>Wm J. Shaw, Jr M.D.</b> (Degree or title)	23b. ADDRESS <b>Lee Hosp, Fayette, Mo</b>	23c. DATE SIGNED <b>8-16-54</b>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	24b. DATE <b>8/10/54</b>	24c. NAME OF CEMETERY OR CREMATORY <b>Fayette City Cemetery</b>	24d. LOCATION (City, town, or county) (State) <b>Fayette, Mo</b>
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DATE REC'D BY LOCAL REG. <b>8-16-54</b>	REGISTRAR'S SIGNATURE <b>Mary T. Shell</b>	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>Walter A. Case Fayette, Mo</b>
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

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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, ~~\_\_\_\_\_~~....., Student Embalmer No..... working under my personal supervision..

Student.....  
Signature of Student Embalmer

Signed *Ralph A. Carr*.....

Licensed Embalmer No. *33*.....

P. O. Address *Gayette,*.....

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.