Health, Welfare Public Service

300
1-56

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

XC- 4 128 166
SL- 8233

FILED SEP 26 1956

THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

STATE FILE NUMBER 32021

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 8223

1. PLACE OF DEATH
a. COUNTY
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: St. Louis, Missouri — Inside Limits Yes X No ☐
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION: Vets. Adm. Hospital — Length of stay in 1b: 94 Days

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Missouri
b. COUNTY: Gasconade
c. CITY OR TOWN: Gasconade 0370 — Inside Limits Yes X No ☐
d. STREET ADDRESS (If outside, give location) — Reside on Farm Yes ☐ No X

3. NAME OF DECEASED (Type or print): First William Middle L Last Feagan
4. DATE OF DEATH: Month 9 Day 4 Year 56
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 2-4-96
9. AGE (In years last birthday): 60 — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS.: Hours, Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): River Pilot
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (City and state or country): Gasconade, Missouri
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: Joseph Feagan
14. MOTHER'S MAIDEN NAME: Minerva Crider
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): Yes — (If yes, give war or dates of service): WW 11
16. SOCIAL SECURITY NO.: 494 32 2458
17. INFORMANT: V. A. Hospital Records, St. Louis, Mo. — Address: 915 N. Grand

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): TUBERCULOSIS, PULMONARY — INTERVAL BETWEEN ONSET AND DEATH: UNKNOWN
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b):
DUE TO (c): .002X
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO X
20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year
20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ NA
20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
20f. CITY, TOWN, OR LOCATION COUNTY STATE

21. I attended the deceased from 6-2-56 to 9-4-56 and last saw her alive on 9-4-56
Death occurred at 9:10 P m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE: Thomas J. Shekleton MD — Degree or Title: M. D.
22b. ADDRESS: V. A. Hospita. 915 N. Grand.
22c. DATE SIGNED: 9-4-56

23a. BURIAL, CREMATION, REMOVAL (Specify): Removal
23b. DATE: 9-5-56
23c. NAME OF CEMETERY OR CREMATORY: Local
23d. LOCATION (City, town, or county) (State): Hermann, Mo.

24. FUNERAL DIRECTOR: Hugo Blumer, Hermann, Mo. — ADDRESS
25. DATE RECD. BY LOCAL REG.: SEP 5 1956
26. REGISTRAR'S SIGNATURE: Earl Smith MD — M.D.

(Licensed Embalmer's Statement on Reverse Side)

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was em

by me, or by ....., Student Embalmer No.....

working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed John L. Kienne

Licensed Embalmer No. 4

P. O. Address St. Lou

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (
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.