

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

12716  
STATE FILE NUMBER

FILED MAY 7 - 1957

Registration District No. 119 Primary Registration District No. 4193 Registrar's No. 7

1. PLACE OF DEATH a. COUNTY <u>GASCONADE</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MO</u> b. COUNTY <u>GASCONADE</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>HERMANN</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <u>HERMANN</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>W. 7th ST</u> Length of stay in lb <u>269RS</u>		d. STREET ADDRESS (If outside, give location) <u>W. 7th ST</u> Reside on Form Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>CHARLES</u> Middle <u>WILLIAM</u> Last <u>FEIL</u>		4. DATE OF DEATH Month <u>APRIL</u> Day <u>2</u> Year <u>1957</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>AUG 13 - 1872</u>
9. AGE (In years last birthday) <u>84</u>	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) <u>FARMER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>FARMING</u>	
11. BIRTHPLACE (City and state or country) <u>HERMANN MO</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>KARL FEIL</u>		14. MOTHER'S MAIDEN NAME <u>AMALIA RONNEBURGER</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT <u>AUGUSTA GREBE</u> Address <u>HERMANN MO</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARCINOMA OF THE PROSTATE</u>  Conditions, if any, which gave rise to above cause (a), stating the underlying cause last <u>→ DUE TO (b) <u>ARTERIOSCLEROTIC HEART DISEASE</u></u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(n)			INTERVAL BETWEEN ONSET AND DEATH <u>54 years</u>  <u>10 years</u>
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			<u>177X</u>
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour _____ Month _____ Day _____ Year _____ a. m. _____ p. m. _____			
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		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 <u>11-12-52</u> to <u>4-2-57</u> and last saw <sup>her</sup> him alive on <u>3-20-57</u> Death occurred at <u>4:15</u> p m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>Cavel T. Shaw, MD</u>		22b. ADDRESS <u>Hermann, Mo</u>	
22c. DATE SIGNED <u>4-4-57</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE <u>4/5/57</u>	23c. NAME OF CEMETERY OR CREMATORY <u>HERMANN CEMETERY</u>	23d. LOCATION (City, town, or county) (State) <u>HERMANN MO</u>
24. FUNERAL DIRECTOR <u>HUGH H. BLUMER</u> ADDRESS <u>HERMANN MO</u>		25. DATE RECD. BY LOCAL REG. <u>4/5/57</u>	
26. REGISTRAR'S SIGNATURE <u>Delma Grebe</u>			

(Licensed Embalmer's Statement on Reverse Side)

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 causally related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

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 .....  
Signature of Student Embalmer

Signed *Chas. W. Pope* .....

Licensed Embalmer No. *255*

P. O. Address *HERMANN*

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.