

FILED DEC 9 - 1957

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

431519
STATE FILE NUMBER

Registration District No. 322 Primary Registration District No. 6087 Registrar's No. 61

V. S. 300
Rev. 1-57

1. PLACE OF DEATH a. COUNTY <u>Saline</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Saline</u>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Cambridge Township</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		c. CITY OR TOWN <u>Cambridge Township</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>3 miles east of Gilliam, Mo.</u>		Length of stay in lb <u>40 years</u>		d. STREET ADDRESS <u>3 miles east of Gilliam, Mo.</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>JOHN</u> Middle <u>JACOB</u> Last <u>FEUERS</u>				4. DATE OF DEATH Month <u>Dec.</u> Day <u>6</u> Year <u>1957</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug. 6, 1875</u>	9. AGE (In years last birthday) <u>82</u>	F 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>farm</u>	11. BIRTHPLACE (City and state or country) <u>Bland, Mo.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		
13a. FATHER'S NAME <u>Chris Feuers</u>		13b. MOTHER'S MAIDEN NAME <u>Catherine Drewel</u>		14. NAME OF HUSBAND OR WIFE <u>Dorothea Feuers</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 Address <u>Chester Feuers, Gilliam, 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>Cornal Occlusion ?</u>						INTERVAL BETWEEN ONSET AND DEATH <u>1 1/2 hr</u>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>Influenza Acute</u>	DUE TO (c) <u>Thrombotic Acute</u>				<u>10 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>480X</u>						19. WAS AUTOPSY PERFORMED? <u>2</u> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
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 _____ 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>Dec. 4 - 57</u> to <u>Dec. 5 - 57</u> and last saw him alive on <u>Dec 5 - 57</u> Death occurred at <u>Home</u> <u>11:15 P</u> m on the date stated above; and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE <u>[Signature]</u> (Degree or title)			22b. ADDRESS <u>Slater Mo</u>		22c. DATE SIGNED <u>Dec. 7 57</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>12/8/1957</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Little Rock</u>	23d. LOCATION (City, town, or county) (State) <u>Saline County, Mo.</u>				
24. FUNERAL DIRECTOR <u>W. J. Haines, Jr. Slater, Mo.</u>		ADDRESS	25. DATE RECD. BY LOCAL REG. <u>12-7-57</u>	26. REGISTRAR'S SIGNATURE <u>[Signature]</u>			

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.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

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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, Student Embalmer No. working under my personal supervision.

Student
Signature of Student Embalmer

Signed *Walter J. Linn*

Licensed Embalmer No. *4557*

P. O. Address *Shelton, Md.*

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.