

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-61-045957
STATE FILE NUMBER

AMENDED

Registration District No. 314 Primary Registration District No. 4459 Registrar's No. 1

FILED JAN 9 1962

1. PLACE OF DEATH a. COUNTY <u>St. Clair</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Benton</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Osceola</u>	Length of stay in lb <u>10 days</u>	c. CITY OR TOWN <u>Quincy</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>Osceola Medical Hosp</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>Route # 1</u>

3. NAME OF DECEASED (Type or print) First <u>Dona</u> Middle <u>-</u> Last <u>Feaster</u>			4. DATE OF DEATH Month <u>Dec</u> Day <u>22</u> Year <u>1961</u>	
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5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>12/5/99</u>	9. AGE (last birthday) <u>62</u>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housekeeping</u>	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <u>Benton County Mo</u>	12. CITIZEN OF WHAT COUNTRY <u>USA</u>
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13a. FATHER'S NAME <u>Jesse Feaster</u>	13b. MOTHER'S MAIDEN NAME <u>Ida Suiter</u>	14. NAME OF HUSBAND OR WIFE
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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>Ethel Harper, Quincy Mo;</u>	Address
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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>Acute right heart failure - 2 1/2 hours</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 1/2 hours</u> <u>year -</u> <u>year -</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>Cor Pulmonale -</u>	
	DUE TO (c) <u>Asthma, Severe</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		PART III. If deceased was female was there a pregnancy in last 90 days <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown

19. WAS AUTOPSY PERFORMED? 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.)
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20c. TIME OF INJURY Hour <u>8:00</u> a.m. p.m.	Month, Day, Year
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20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION <u>Osceola Missouri</u>	COUNTY <u>St. Clair</u>	STATE <u>Missouri</u>
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21. I attended the deceased from <u>July 15, 1961</u> to <u>Dec 22, 1961</u> and last saw her alive on <u>Dec 22, 1961</u>
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Death occurred at <u>8: P.M.</u> on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <u>S. D. Kern M.D.</u>	22b. ADDRESS <u>Osceola Missouri</u>	22c. DATE SIGNED <u>12/23/61</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>12/26/61</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Iconium</u>	23d. LOCATION (City, town, or county) (State) <u>Iconium Mo</u>
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24. FUNERAL DIRECTOR <u>Goodrich F. Home, Osceola Mo.</u>	ADDRESS	25. DATE RECD. BY LOCAL REG. <u>1-6-1962</u>	26. REGISTRAR'S SIGNATURE <u>Ruth Seever</u>
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DATE AMENDED

INSTEAD OF DOCUMENT

ITEM NO. SHOULD READ BY AFFIDAVIT OF

MEDICAL CERTIFICATION

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 J. B. Broadbush

Licensed Embalmer No. 3038

P. O. Address Oskaloosa, Ia

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.