

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

=63-020785

STATE FILE NUMBER

Registration District No. 209 Primary Registration District No. \_\_\_\_\_ Registrar's No. 16

**FILED MAY 27 1963**

1. PLACE OF DEATH a. COUNTY <u>MARION</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>KNOX</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>4 mi.</u>		c. CITY OR TOWN <u>KNOX CITY</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>Maple Lawn Rest Home</u>		d. STREET ADDRESS (If outside, give location)	Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Pinkie</u> Middle <u>G.</u> Last <u>Feigonspan</u>			4. DATE OF DEATH Month <u>MAY</u> Day <u>5</u> Year <u>1963</u>
5. SEX <u>Female</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>NOV 1 - 1882</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>	9. AGE (last birthday) <u>80</u> IF UNDER 1 YEAR: Months _____ Days _____ Hours _____ Min. _____ IF UNDER 24 HR: Months _____ Days _____ Hours _____ Min. _____
11. BIRTHPLACE (City and state or country) <u>NEWARK Mo</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13a. FATHER'S NAME <u>ALBERT BARNES</u>		13b. MOTHER'S MAIDEN NAME <u>ANNA SKAGGS</u>	
14. NAME OF HUSBAND OR WIFE <u>NOBIE Feigonspan, PALMIRA Mo.</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of ser) <u>No</u>	
16. SOCIAL SECURITY NO.		17. INFORMANT <u>NOBIE Feigonspan, PALMIRA 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>Senile Dementia</u> DUE TO (b) <u>Cerebral Thrombosis</u> DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH
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 type="checkbox"/> No <input type="checkbox"/> Unknown
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input 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. Month, Day, Year _____			
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 _____ to <u>5-5-63</u> and last saw her alive on <u>5-3-63</u> Death occurred at <u>5 pm</u> on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>E. M. Lucke MD</u>		22b. ADDRESS <u>Hannibal Mo</u>	22c. DATE SIGNED <u>5-6-63</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>5-7-1963</u>	23c. NAME OF CEMETERY OR CREMATORY <u>ASBURY Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>SE. STEFFENVILLE Mo.</u>
24. FUNERAL DIRECTOR <u>Anna K. Ball</u>		25. DATE RECD. BY LOCAL REG. <u>5-6-63</u>	26. REGISTRAR'S SIGNATURE <u>Dr. E. M. Lucke</u> <u>By Viola Sec. Deputy</u>

DO NOT WRITE ON THIS STUB

AMENDED

VS 300  
Rev. 4/59

10640

20520

3

4 1

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9332X

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12 86-0

13 1-0

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

USE BLACK INK OR TYPEWRITER RIBBON

**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 L. M. Crabbell

Licensed Embalmer No. 4905

P. O. Address Ewing Mo.

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.