

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

63-035589

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 098 Primary Registration District No. 4161 Registrar's No. 90

FILED SEP 24 1963

VS 300
Rev. 4/59
10310
20310
3
4 0
5 2
6
7 0
8 2
94500
10
11
12 90-0
13 1-0

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY <u>Daviess</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> COUNTY <u>Daviess</u>	
b. CITY (if outside corporate limits, give TOWNSHIP only) <u>Jameson</u>		Length of stay in 1b <u>15 Yrs.</u>	c. CITY OR TOWN <u>Jameson</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>---</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (if outside, give location) <u>---</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Cort</u> Middle <u>Feurt</u> Last <u>Feurt</u>			4. DATE OF DEATH Month <u>September</u> Day <u>13</u> Year <u>1963</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>6-27-1873</u>
9. AGE (last birthday) <u>90</u>		10. KIND OF BUSINESS OR INDUSTRY <u>Farm Owner</u>	11. BIRTHPLACE (City and state or country) <u>Daviess Co. Missouri USA</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13a. FATHER'S NAME <u>Thomas A. Feurt</u>		13b. MOTHER'S MAIDEN NAME <u>Mary Elizabeth Prewitt</u>	
14. NAME OF HUSBAND OR WIFE <u>Ella Feurt (Dec'd)</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of) <u>No</u>	
16. SOCIAL SECURITY NO. <u>---</u>		17. INFORMANT <u>38 Boyd Feurt, Jameson, Mo.</u>	
18. CAUSE OF DEATH (Enter only one cause per PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardio-Respiratory Failure</u> Atherosclerosis DUE TO (b) <u>---</u> DUE TO (c) <u>---</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH <u>3 months</u> <u>unknown</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 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.)	
20c. TIME OF INJURY Hour <u>---</u> a.m. <u>---</u> p.m. Month, Day, Year <u>---</u>	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>Sep. 28, 1961</u> to <u>Sep. 13, 1963</u> and last saw ^{her} him alive on <u>Sep. 13, 1963</u> Death occurred at <u>10:45 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>Larry Donnell MD</u>		22b. ADDRESS <u>Pattersonburg, Mo.</u>	22c. DATE SIGNED <u>Sep. 16, 1963</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>9-15-1963</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Grand River Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>Daviess Co. Missouri</u>
24. FUNERAL DIRECTOR <u>Hope Funeral Home, Gallatin, Mo.</u>		25. DATE RECD. BY LOCAL REG. <u>9-18-63</u>	26. REGISTRAR'S SIGNATURE <u>Deputy Registrar</u>

USE BLACK INK OR TYPEWRITER RIBBON

Permit Rec 9-18-63 (2E)
Permit no 617

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. Lichesson

Licensed Embalmer No. 3302

P. O. Address Galatin, 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.