MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

Do not use this space.
36491

1. PLACE OF DEATH
County: Polk
Township: [illegible]
City: ..... (No. ....., ... St. ..... Ward)
Registration District No. 242
Primary Registration District No. 5335
File No. 10
Registered No. .....

2. FULL NAME Henry G Fellers
(a) Residence. No. ..... St., ... Ward.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write* the word): married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF: Martha Fellers

6. DATE OF BIRTH (MONTH, DAY AND YEAR)

7. AGE: Years 88 | Months 4 | Days 6 | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Farmer
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): Tenn

PARENTS
10. NAME OF FATHER: Jeff Fellers
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY): not known
12. MAIDEN NAME OF MOTHER: " "
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY): Tenn

14. INFORMANT: Frank Fellers
(Address): Polk Mo

15. FILED 12 Nov 1928 Albert Booth REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR): Nov 15 1928

17. I HEREBY CERTIFY, That I attended deceased from Nov 4, 1928, to Nov 12, 1928 that I last saw h— alive on Nov 12, 1928 and that death occurred, on the date stated above, at 12-30 A.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Uremic Poisoning
137
1328
..... (duration) ..... yrs. ..... mos. 13 ds.

CONTRIBUTORY (SECONDARY): Enlarged Prostate
..... (duration) ..... yrs. ..... mos. ..... ds.

18. WHERE WAS DISEASE CONTRACTED IF NOT AT PLACE OF DEATH? .....
DID AN OPERATION PRECEDE DEATH? ..... DATE OF .....
WAS THERE AN AUTOPSY? .....
WHAT TEST CONFIRMED DIAGNOSIS? .....
(Signed) W E Gammon, M. D
, 19 (Address) Lonsburg Mo

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL: Payne Cemt
DATE OF BURIAL: Nov 16 1928

20. UNDERTAKER: Hutcheson-Blue
ADDRESS: Bolivar

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

MISSOURI STATE BOARD OF HEALTH
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CERTIFICATE OF DEATH

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH
County Dallas Registration District No. 242 File No. 10
Township Grant Primary Registration District No. 5335 Registered No.
City (No. St. Ward)

2. FULL NAME Henry G. Fellers
(a) Residence. No. St., Ward.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M
4. COLOR OR RACE W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) m

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF E Fellows

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 7-9-1839

7. AGE Years 88 Months 4 Days 6 If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Tenn

PARENTS
10. NAME OF FATHER John Fellows
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) Tenn
12. MAIDEN NAME OF MOTHER Doris Knox
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) Tenn Knox

14. INFORMANT Wife Fellows
(Address) Sentinel

15. FILED 12-10, 1929 Albert Booth REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Nov 15 1928

17. I HEREBY CERTIFY, That I attended deceased from 11-6 1928 to 11/12 1928 that I last saw him alive on 11/12 1928, and that death occurred, on the date stated above, at 4:15 m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Nephritis Sonnine
Trauma Enlarged Prostate Gland
(duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY) 125
(duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED IF NOT AT PLACE OF DEATH?
DID AN OPERATION PRECEDE DEATH? DATE OF
WAS THERE AN AUTOPSY?
WHAT TEST CONFIRMED DIAGNOSIS?
(Signed) , M. D
, 19 (Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL | DATE OF BURIAL 19

20. UNDERTAKER | ADDRESS

SUPPLEMENTARY

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

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