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
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

Do not use this space.

38111

1. PLACE OF DEATH NOV 22 1934

County St. Louis Registration District No. 1123 File No.

Township Carondelet Primary Registration District No. 6248 B Registered No. 364

City Jefferson Barracks, Missouri, Veterans Administration Facility St. Ward)

2. FULL NAME Willis L. FELTS

(a) Residence, No. Route #1, Johnson City St., Illinois Ward. (If nonresident, give city or town and State)
(Usual place of abode)

Length of residence in city or town where death occurred Un yrs. kn mos. own ds. How long in U. S., if of foreign birth? — yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

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

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Mrs. Beatrice Felts

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Mar. 17, 1892

7. AGE YEARS	MONTHS	DAYS	If LESS than 1 day, ...hrs. or ....min.
42	7	0	

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Farmer

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. Self-employed

10. Date deceased last worked at this occupation (month and year) August 2, 1934

11. Total time (years) spent in this occupation 2 yrs.

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Williamson Co., Illinois.

FATHER

13. NAME Thomas J. Felts

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Unavailable Illinois

MOTHER

15. MAIDEN NAME Sarah Gambrill

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Unavailable Illinois

17. INFORMANT (ADDRESS) C. M. SMITH, M.D., Clinical Director, Vet.Adm.Fac. Jeff.Brks., Mo.

18. BURIAL, CREMATION, OR REMOVAL PLACE Johnston City DATE Oct 19, 1934

19. UNDERTAKER (ADDRESS) John Hatchaway Johnston City Ill.

20. FILED 10-17, 1934 B. A. Tate M.D. Registrar.

MEDICAL CERTIFICATE OF DEATH

5

21. DATE OF DEATH (MONTH, DAY, AND YEAR) October 17, 1934

22. I HEREBY CERTIFY, That I attended deceased from August 15, 1934, to October 17, 1934

I last saw him alive on October 17, 1934. Death is said to have occurred on the date stated above, at 3:33AM.

The principal cause of death and related causes of importance were as follows:

	Date of onset
Myocarditis with hypertrophy and dilatation, congstive type of cardiac failure.	Unk.

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Other contributory causes of importance:

Nephritis, chr. with mild nitrogen retention	Unk.
Hypertension, severe.	Unk.
Arteriosclerosis, peripheral.	Unk.

Name of operation None Date of

What test confirmed diagnosis? History, physical, clinical, laboratory X-ray Was there an autopsy? No

23. If death was due to external causes (violence), fill in also the following:

Accident, suicide, or homicide? Date of injury, 19

Where did injury occur? (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place.

Manner of injury

Nature of injury

24. Was disease or injury in any way related to occupation of deceased?

If so, specify

(Signed) W. C. GIBSON, M.D., Acting Chief Medical Officer, M. D.

(Address) Vet.Adm.Fac. Jeff.Brks., Mo.