

REC'D JUL 14 1938

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

21358

Do not use this space.

1. PLACE OF DEATH

(a) County Buchanan Registration District No. 85

(b) Township \_\_\_\_\_ Primary Registration District No. 1001 Registered No. 612

(c) City St. Joseph (d) Street No. Mercy Hospital St. \_\_\_\_\_  
 (If death occurred in Hospital or Institution, write its name instead of street and number)

(e) Length of residence in city or town where death occurred 15 yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME Rose Feitz 320

(a) Residence, No. 2115 Mitchell Avenue St.  (If nonresident, give city or town and State)  
 (Usual place of abode, if no street address, write county or city)

## PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 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 John E Feitz

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Aug. 11, 1877.

7. AGE YEARS MONTHS DAYS If LESS than 1 day, .....hra. or .....min.

60 9 28

OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Housewife.

9. Industry or business in which work was done, as saw mill, bank, etc. \_\_\_\_\_

10. Date deceased last worked at this occupation (month and year) Unknown. 11. Total time (years) spent in this occupation Unk.

12. BIRTHPLACE (CITY OR TOWN) Hughesville 0  
 (STATE OR COUNTRY) Missouri

FATHER 13. NAME Phillip W Voigt 6

14. BIRTHPLACE (CITY OR TOWN) Unknown 7  
 (STATE OR COUNTRY) Germany

MOTHER 15. MAIDEN NAME Mary Klaptach.

16. BIRTHPLACE (CITY OR TOWN) Unknown.  
 (STATE OR COUNTRY) Austria.

17. INFORMANT John E. Feitz.  
 (ADDRESS) 2115 Mitchell Ave.

18. BURIAL, CREMATION, OR REMOVAL Memorial Park.  
 PLACE St. Joseph Mo. DATE June 11 '38

19. FUNERAL DIRECTOR H. O. Sidenfaden & Son.  
 (ADDRESS) 1802 Union St. St. Joseph Mo.

20. FILED 6/10 1938 J.A. Westlund  
 Local Registrar.

## MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) June 9th 1938

22. I HEREBY CERTIFY, That I attended deceased from May 22, 1938, to June 9, 1938

I last saw her alive on June 9, 1938. Death is said

to have occurred on the date stated above, at 11:30 a.m.

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

Cardiac failure Date of onset May 23

Other contributory causes of importance:  
Intestinal obstruction  
Peritonitis

Name of operation Intestinal Resection Date of May 23

What test confirmed diagnosis? Operation Was there an autopsy? Yes

23. If death was due to external causes (violence), fill in also the following:  
 Accident, suicide, or homicide? No 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? No

If so, specify \_\_\_\_\_

(Signed) H. A. N. Tappan M.D.

(Address) 411 N. K. K. K.

122 B-

STATEMENT BY LICENSED EMBALMER

I, Robert P. Clarkson Licensed Embalmer No. 4028

hereby certify that the body recorded on the reverse side of this certificate was embalmed by my-self

✓ L. E. ✓

No. ✓ or by ✓ Registered Apprentice No. ✓

working under my personal supervision.

Signed Robert P. Clarkson

Licensed Embalmer No. 4028

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.)

FILL IN ANSWERS TO ALL SPACES  
CHECKED IN RED PENCIL.

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

2135-8  
Do not use this space.

1. PLACE OF DEATH

(a) County Buchanan Registration District No. 85  
(b) Township St Joseph Primary Registration District No. 1001  
(c) City St Joseph (d) Street No. \_\_\_\_\_ St.  
(If death occurred in Hospital or Institution, write its name instead of street and number)  
(e) Length of residence in city or town where death occurred 3 yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

Registered No. 612

2. PRINT FULL NAME

(a) Residence, No. \_\_\_\_\_ St.  (If nonresident, give city or town and State)  
Rose Feitz  
(Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

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

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 6-9, 1938

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

22. I HEREBY CERTIFY, That I attended deceased from \_\_\_\_\_ to \_\_\_\_\_, 19\_\_\_\_.

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

I last saw h. \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_. Death is said to have occurred on the date stated above, at \_\_\_\_\_ m.

7. AGE YEARS MONTHS DAYS If LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.  
60 9 28

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

OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. \_\_\_\_\_  
9. Industry or business in which work was done, as saw mill, bank, etc. \_\_\_\_\_  
10. Date deceased last worked at this occupation (month and year) \_\_\_\_\_ 11. Total time (years) spent in this occupation \_\_\_\_\_

Cardiac failure  
122B2  
Date of onset \_\_\_\_\_

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

Other contributory causes of importance:  
intestinal obstruction  
Peritonitis general  
admission from a former opium

FATHER 13. NAME

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

MOTHER 15. MAIDEN NAME

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

17. INFORMANT (ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL PLACE DATE 19\_\_\_\_

19. FUNERAL DIRECTOR (ADDRESS)

20. FILED \_\_\_\_\_, 19\_\_\_\_ Local Registrar.

Name of operation 12 years ago. Date of \_\_\_\_\_  
What test confirmed diagnosis? \_\_\_\_\_ Was there an autopsy? \_\_\_\_\_

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) H. N. Thompson (M. D.)  
(Address) 111 W. Washington St.

REGISTRARS, SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.  
CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

SUPPLEMENTARY

