REC'D APR 1 7 1939

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

9456
Do not use this space.

1062

1. PLACE OF DEATH
(a) County Jackson — Registration District No. 399
(b) Township Kan — Primary Registration District No. 1002 — Registered No.
or
(c) City K.C. Mo. — (d) Street No. St Luke Hosp. 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 yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME 621 Lyman Robert Feorgrave
(a) Residence, No. St Joseph Mo St. ☐ x
(Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

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 Elvie E. Feorgrave

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Sept 26 1876

7. AGE — YEARS: 62 — MONTHS: 5 — DAYS: 13 — If LESS than 1 day, ... hrs. or ..... min.

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

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

FATHER
13. NAME Lyman W. Feorgrave
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Ohio

MOTHER
15. MAIDEN NAME Nancy Ann Sales
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Iowa

17. INFORMANT (ADDRESS) Dr Paul Feorgrave St Joseph Mo

18. BURIAL, CREMATION, OR REMOVAL
PLACE St Joseph Mo DATE 3-10 1939

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Mrs. C. L. Forster K.C. Mo.

20. FILED Mch 9, 1939 M. M. Crowe
Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 3/9, 1939

22. I HEREBY CERTIFY, That I attended deceased from March 5, 1939, to March 9, 1939
I last saw him alive on March 9, 1939. Death is said to have occurred on the date stated above, at 2:20 p.m.
The principal cause of death and related causes of importance were as follows:

	Date of onset
Suppurative bronchiolitis	3-3-39
Suppurative pneumonitis	3-3-39
109 b	

Other contributory causes of importance:

Chronic bronchitis	1920?
Chronic emphysema	1937
Bronchial asthma	1938 (Aug)

Name of operation None Date of
What test confirmed diagnosis? Autopsy Was there an autopsy? Yes

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? No
If so, specify
(Signed) P. T. Bohan, M.D.
(Address) 315 Alameda Road K.C. Mo.

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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.

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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.....

....., Registered Apprentice No.....

working under my personal supervision.

Signed.....

Licensed Embalmer No.....

P. O. Address.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to compl with the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.