

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 33635

Registration District No. 809

Primary Registration District No. 6054

Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH:  
(a) County Scotland  
(b) City or town "Rural" Harrison  
(c) Name of hospital or institution: \_\_\_\_\_  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_  
(Specify whether \_\_\_\_\_)  
In this community \_\_\_\_\_  
years, months or days

2. USUAL RESIDENCE OF DECEASED:  
(a) State Missouri (b) County Scotland  
(c) City or town "Rural"  
(If outside city or town limits, write "RURAL")  
(d) Street No. \_\_\_\_\_  
(If rural, give location)  
(e) If foreign born, how long in U. S. A.? 86 years.

3. (a) PRINT FULL NAME Adam Fehr  
3. (b) If veteran, name war \_\_\_\_\_  
3. (c) Social Security No. \_\_\_\_\_

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month Aug day 8  
year 1939 hour 6 minute a.m.

4. Sex Male 5. Color or race White  
6. (a) Single, widowed, married, divorced married  
6. (b) Name of husband or wife Elizabeth Fehr  
6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
7. Birth date of deceased Nov. 2 1856  
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from July 10, 1939 to Aug 8, 1939 that I last saw him alive on Aug 5 = 1939 and that death occurred on the date and hour stated above.

8. AGE: Years Months Days If less than one day  
88 9 6 hr. \_\_\_\_\_ min.

Immediate cause of death lack of breath  
Duration 8 days

9. Birthplace Germany  
(City, town, or county) (State or foreign country)  
10. Usual occupation Farmer

Due to  \_\_\_\_\_  
Due to  \_\_\_\_\_  
Other conditions enlarged prostate  
(include pregnancy within 3 months of death)

11. Industry or business \_\_\_\_\_  
12. Name John Fehr  
13. Birthplace Germany  
(City, town, or county) (State or foreign country)  
14. Maiden name Anna Barbara  
15. Birthplace Germany  
(City, town, or county) (State or foreign country)

Major findings:  
Of operations   
Of autopsy

16. (a) Informant's own signature Lydia Fehr  
(b) Address Gorin

PHYSICIAN  
Underline the cause to which death should be charged statistically.

17. (a) Burial (b) Date thereof Aug. 10, 1939  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation Gorin Cemetery

22. If death was due to external causes, fill in the following:  
(a) Accident, suicide, or homicide (specify)   
(b) Date of occurrence   
(c) Where did injury occur? \_\_\_\_\_ (City or town) (County) (State)  
(d) Did injury occur in or about home, on farm, in industrial place, in public place?

18. (a) Signature of funeral director Geo V. Shacklett  
(b) Address Gorin  
19. (a) Oct 3-39 (b) Geo R. Shacklett  
(Date received local registrar) (Registrar's signature)

While at work?  (Specify type of place) (e) Means of injury   
23. Signature Don Pined (M. D. or other)  
Address Wyannda mo Date signed Oct 5/39

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

1226  
APR 20 1942

RECEIVED

District Health Officer No. 10

District File Number 10-39-1757

Date Filed OCT 9 1939

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 Geo. V. Basket

Licensed Embalmer No. 1817

P. O. Address Gorin, m

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

FILL IN ANSWERS TO ALL SPACES  
CHECKED IN RED PENCIL.

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

33635  
Do not use this space.

1. PLACE OF DEATH

(a) County Seathland Registration District No. 809  
(b) Township Harrison Primary Registration District No. 6054 Registered No. ....  
(c) City ..... (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 yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME Adam Fehr

(a) Residence, No. .... 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 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 .....  
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) .....  
7. AGE YEARS 88 MONTHS 9 DAYS 6 IF LESS than 1 day, .... hrs. or ..... min.

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. ....

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

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 Sept 2 19 39 Frank Huckler Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Aug 8 1939

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

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

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

Robert Bowels  
Intestinal obstruction  
Do not know cause  
Date of onset 10/1  
Other contributory causes of importance:  
Enlarged Prostate

Name of operation none Date of ..... 2

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) Don Pierce M. D.

(Address) Wyaconda Mo

SUPPLEMENTARY

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

