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WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF VITAL STATISTICS

FILED MAR 7 - 1940

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 7095

Registration District No. 437

Primary Registration District No. 5594

Registrar's No.

1. PLACE OF DEATH:

(a) County Johnson

(b) City or town La Tour Mo. Rural Rte No 2
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: Residence of Ora Feeback, La Tour, Mo.
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 2 (Specify whether years, months or days)

In this community 50 years.

2. USUAL RESIDENCE OF DECEASED:

(a) State MO (b) County Johnson

(c) City or town La Tour MO
(If outside city or town limits, write "RURAL")

(d) Street No. R R Rte Nice, Ora Feeback
(If rural, give location)

(e) If foreign born, how long in U. S. A.? no years.

3. (a) PRINT FULL NAME Horace Feeback

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex Male

5. Color or race White

6. (a) Single, widowed, married, divorced Widower

6. (b) Name of husband or wife

6. (c) Age of husband or wife if alive years

7. Birth date of deceased Sept. (Month) 20 (Day) 1858 (Year)

8. AGE: Years 81 Months 3 Days 23 If less than one day hr. min.

9. Birthplace Nicholas Co. (City, town, or county) Ky. (State or foreign country)

10. Usual occupation Farmer

11. Industry or business Retired

MOTHER FATHER

12. Name Eliza Feeback

13. Birthplace Kentucky (City, town, or county) (State or foreign country)

14. Maiden name Mary Jane McDonald

15. Birthplace Kentucky (City, town, or county) (State or foreign country)

16. (a) Informant Jasper Dillard

(b) Address Latour Mo

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/15/40 (Month) (Day) (Year)

(c) Place: burial or cremation Garden City Cemetery

18. (a) Signature of funeral director Ruth Kauffman

(b) Address Garden City, Missouri

19. (a) Jan 13 (Date received local registrar) (b) Emma M Coleman (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan day 13 year 1940 hour 1 minute 12:34 P.M.

21. I hereby certify that I attended the deceased from Jan 1 1940 to Jan 13 1940 that I last saw him alive on Jan 13 1940 and that death occurred on the date and hour stated above.

Immediate cause of death Cardiac Insufficiency Chr. myocarditis

Due to Decompensation

Due to

Other conditions None
(Include pregnancy within 3 months of death)

Duration

Major findings: Of operations None

Of autopsy no

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

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) no

(b) Date of occurrence no

(c) Where did injury occur? no (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? no (Specify type of place)

While at work? no (e) Means of injury no

392 23. Signature G W Griffith (M. D. or other)

Address Garden City Date Jan 15 1940

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 8,
District File Number
Date Filed 2/26/40

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~~ and J. M. Kauffman #1030, Registered Apprentice No. _____, working under my personal supervision.

Signed Reed Kauffman

Licensed Embalmer No. 4801

P. O. Address Garden City, Mo

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.