

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

16068

State File No.

Registrar's No.

Registration District No. 784

Primary Registration District No. 300

1. PLACE OF DEATH:

(a) County Saint Louis
(b) City or town Clayton
(c) Name of hospital or institution: Saint Louis County Hosp #2
(d) Length of stay: In hospital or institution 2 Days
In this community 52 Years

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Saint Louis
(c) City or town Lamay
(d) Street No. 104 Kayser
(e) If foreign born, how long in U. S. A. _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 10th
year 1940 hour 10 minute _____ P. M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;
that I last saw him _____ alive on _____, 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death
A accidental burn
(2nd degree) of 80% of
skin surface -
Gasoline exploding while
filling a small blow
tank
Due to _____ 5/8/40
Due to _____ 5/8/40
Other condition _____
(Include pregnancy within 3 months of death)

Duration

PHYSICIAN

Major findings:
Of operations _____
Of autopsy _____
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) Accident
(b) Date of occurrence May 8, 1940
(c) Where did injury occur? Lamay Mo.
(d) Did injury occur in or about home, on farm, in industrial place, in public place?
Home
While at work? yes (Specify type of place) _____
(e) Means of injury Gasoline tank
23. Signature John O'Connell (M. D. or other)
Address Lamay, Mo. Date signed 5/10/40

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

3. (a) PRINT FULL NAME Alexander J. Feager 260

8. (b) If veteran, name war _____ 3. (c) Social Security No. 488-10-226

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Olivia Feager 6. (c) Age of husband or wife if alive 45 years

7. Birth date of deceased November 15 1887
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>52</u>	<u>5</u>	<u>25</u>	hr. _____ min. _____

9. Birthplace Saint Louis Missouri
(City, town, or county) (State or foreign country)

10. Usual occupation Painter

11. Industry or business Paulk Fixture Co.

12. Name Joseph A. Feager

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

14. Maiden name Francis Becker

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

16. (a) Informant Olivia Feager

(b) Address 104 Kayser Lemay Mo.

17. (a) Cremation (b) Date thereof May 14, 1940
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Missouri Crematory

18. (a) Signature of funeral director Southern Funeral Home
(b) Address 6322 B. Road

19. (a) MAY 11 1940 (b) R. R. Myers M.D.
(Date received local registrar) (Registrar's signature)

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 Virgil L. Berryman

Licensed Embalmer No. 4018

P. O. Address St Louis 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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 16068
Registrar's No. 917

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. 784

Primary Registration District No. 200101

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

1. PLACE OF DEATH:

(a) County St. Louis
(b) City or town St. Louis
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: St. Louis Co. Hosp.
(If not in hospital or institution, write street number and location)
(d) Length of stay: In hospital or institution 2 da
In this community 52 yrs. (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County _____
(c) City or town _____ (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.? _____ years.

3. (a) PRINT FULL NAME

Alexander J. Feager

(b) If veteran, name war _____

(c) Social Security No. _____

4. Sex m 5. Color or race w 6. (a) Single, widowed, married, divorced m

6. (b) Name of husband or wife _____ 6. (c) Age of husband, or wife, if alive _____ years

7. Birth date of deceased (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day _____ hr. _____ min.

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

10. Usual occupation _____

11. Industry or business _____

12. Name _____

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

14. Maiden name _____

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

16. (a) Informant _____

(b) Address _____

17. (a) _____ (b) Date thereof (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (b) _____ (Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 10-40 year _____ hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____; that I last saw him _____ alive on _____, 19____; and that death occurred on the date and hour stated above.

Immediate cause of death Acid-burns

Due to _____

Due to _____

Other conditions (Include pregnancy within 3 months of death) _____

Major findings: Of operations _____

Of autopsy _____

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?

While at work? (Specify type of place) (e) Means of injury _____

23. Signature _____ (M. D. or other) _____

Address _____ Date signed _____

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

SUPPLEMENTARY

