

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.

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

21713

Do not use this space.

1. PLACE OF DEATH

(a) County Cass
 (b) Township Roark
 (c) City

(d) Street No. 303
 Registration District No. 303
 Primary Registration District No. 5420

Registered No. _____

(e) Length of residence in city or town where death occurred

(f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME

(a) Residence, No. _____

(Usual place of abode, if no street address, write county or city)

St. ☐

(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 Emilie Feil

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Mar. 1 - 1859

7. AGE YEARS 81 MONTHS 3 DAYS 7 If LESS than 1 day, _____ hrs. or _____ min.

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Farmer
 9. Industry or business in which work was done, as saw mill, bank, etc. Retired
 10. Date deceased last worked at this occupation (month and year) _____ 11. Total time (years) spent in this occupation 0

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

13. NAME Jacob Feil
 14. BIRTHPLACE (CITY OR TOWN) Germany (STATE OR COUNTRY) Mo.

15. MAIDEN NAME Frieda Reuter
 16. BIRTHPLACE (CITY OR TOWN) Germany (STATE OR COUNTRY) Mo.

17. INFORMANT Mrs. Emilie Feil (ADDRESS) _____

18. BURIAL, CREMATION, OR REMOVAL PLACE German DATE 6/11/40

19. FUNERAL DIRECTOR (NAME) H. G. Rickhoff (ADDRESS) _____

20. FILED 6-9 19 40 Anna K. Rickhoff Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) June 8 19 40

22. I HEREBY CERTIFY That I attended, deceased from May 1 19 40 to June 8 19 40

I last saw him alive on June 6 19 40. Death is said

to have occurred on the date stated above, at 4 P. m.

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

Endocarditis Date of onset _____

Other contributory causes of importance:

Arterial sclerosis, aortic and enlargement of heart

Name of operation _____ 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. G. Rickhoff M. D.

274 (Address) Thompson Mo

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 myself

....., Registered Apprentice No.
working under my personal supervision.

Signed

H. Rudiger

Licensed Embalmer No. 2044

P. O. Address Herrman Rd

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. 21713

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. 303

Primary Registration District No. 5420

Registrar's No. _____

1. PLACE OF DEATH:

- (a) County Washington
(b) City or town Boonville
(If outside city or town limits, write "RURAL" and name of township)
(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)

3. (a) PRINT FULL NAME Gustav Feil

3. (b) If veteran, name war _____

3. (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 81 Months 3 Days 7 If less than one day _____ 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)

2. USUAL RESIDENCE OF DECEASED:

- (a) State Missouri (b) County Sassaparilla
(c) City or town Neumann - Rural
(If outside city or town limits write "RURAL")
(d) Street No. R75 #2 (If rural, give location)
(e) If foreign born, how long in U. S. A. ? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 8
year 1940 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 _____

- 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 J. Rickhoff (M. D. or other) _____
Address Neumann Date signed _____

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

SUPPLEMENT

