

**AUG 10 1940** **85**  
Registration District No. \_\_\_\_\_

Primary Registration District No. **1001**

Registrar's No. **731**

1. PLACE OF DEATH:

(a) County Buchanan  
(b) City or town St. Joseph  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
631 So. 10 Street  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution none  
In this community 76 years  
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Buchanan  
(c) City or town St. Joseph  
(If outside city or town limits, write "RURAL")  
(d) Street No. 631 South 10th St  
(If rural, give location)  
(e) If foreign born, how long in U. S. A. ? \_\_\_\_\_ years.

3. (a) PRINT FULL NAME 452 Louise Dorothy Felling

3. (b) If veteran, name war none 3. (c) Social Security No. none

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

6. (b) Name of husband or wife William 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased November 29, 1863  
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	76	7	8	hr. _____ min. _____

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

10. Usual occupation housewife  
home

11. Industry or business 9

12. Name Jacob Wingerter

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

14. Maiden name unknown

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

16. (a) Informant Gerald W. Felling  
(b) Address 631 South 10th St

17. (a) Burial (b) Date thereof 7-9-40  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Mt. Olivet Cemetery  
Tracy Barry Funeral

18. (a) Signature of funeral director Tracy Barry Funeral  
(b) Address 218 South 10th St St Joseph,

19. (a) 7/9/40 (b) H. J. West  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 7th  
year 1940 hour 10 minute 15 A.M.

21. I hereby certify that I attended the deceased from July 6  
1940 to July 7, 1940  
that I last saw her alive on July 6, 1940  
and that death occurred on the date and hour stated above.

Immediate cause of death Infarcted obs -  
Jan 19/40

Due to unknown - 1278

Due to \_\_\_\_\_  
Other conditions Paralysis of eyes  
(Include pregnancy within 3 months of death)

Major findings: \_\_\_\_\_  
Of operations \_\_\_\_\_

Of autopsy none

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) \_\_\_\_\_  
(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? \_\_\_\_\_

Home 35 (Specify type of place)  
While at work? \_\_\_\_\_ (b) Means of injury \_\_\_\_\_

23. Signature Don H. Hartigan (M. D. or other)  
Address Fernpark Blaf Date signed 7/8/40

**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.....

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

working under my personal supervision.

Signed

*John E. Myers*

Licensed Embalmer No. *3220*

P. O. Address *St. Joseph, Minn.*

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

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