

FILED SEP 25 1940

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **27320**

Registration District No. **791**

Primary Registration District No. **1003**

Registrar's No. **7216**

1. PLACE OF DEATH:

(a) County _____
(b) City or town St. Louis
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Deaconess Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether)
In this community 40 Years
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State 0 Missouri (b) County _____
(c) City or town St. Louis
(If outside city or town limits, write "RURAL")
(d) Street No. 1227 Sullivan Ave.
(If rural, give location)
(e) If foreign born, how long in U. S. A. ? _____ years.

8. (a) PRINT FULL NAME John F. Fellhauer **460**

8. (b) If veteran, name war No. 8. (c) Social Security No. None.

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

6. (b) Name of husband or wife Anna Fellhauer 6. (c) Age of husband or wife if alive 58 years

7. Birth date of deceased July 26th 1878
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
62 1 0 hr. min.

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

10. Usual occupation Unemployed

11. Industry or business _____

MOTHER FATHER { 12. Name John Fred Fellhauer

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

14. Maiden name Louisa Copf

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

16. (a) Informant Anna Fellhauer

(b) Address 1227 Sullivan Ave.

17. (a) Burial (b) Date thereof 8-29-40
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Memorial Park cem.

18. (a) Signature of funeral director Hy. Lidner and Co

(b) Address 2223 St. Louis Ave.

19. (a) AUG 27 1940 (b) J. P. Bredek
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month August day 26
year 1940 hour 11 minute 48 a M.

21. I hereby certify that I attended the deceased from Dec. 1939
to Aug. 26, 1940
that I last saw him alive on Aug. 26, 1940
and that death occurred on the date and hour stated above.

Immediate cause of death Cardio-renal-vascular disease.

Due to Asthma -- arteriosclerosis
Hypertension

Other conditions 131
(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 1

23. Signature W. B. ... (M. D. or other) MD
Address 3621 N. 20th Date signed 8/27

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

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

3621 N. 20th St.

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 A. Buckner
Licensed Embalmer No. 1674
P. O. Address 2723 So. Linn St.

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.