

Registration District No. **404** Primary Registration District No. **5558** Registrar's No. _____

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

1. PLACE OF DEATH:

(a) County Jackson

(b) City or town Grandview Mo.
(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 83 yrs. years, months or days

3. (a) PRINT FULL NAME JOHN B. FELAND

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 Widowed

6. (b) Name of husband or wife Martha Feland

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

7. Birth date of deceased Feb 12 1857
(Month) (Day) (Year)

8. AGE: Years 83 Months 8 Days 11 If less than one day _____ hr. _____ min.

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

10. Usual occupation Farmer

11. Industry or business _____

12. Name Thomas J. Feland

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

14. Maiden name Caliga Stigall

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

16. (a) Informant Mrs. Joseph P. Ryan

(b) Address Grandview Mo.

17. (a) Burial (b) Date thereof Oct. 25, 1940
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Forest Hill R.C. Ch. Mo.

18. (a) Signature of funeral director B. T. Brown & Sons

(b) Address _____

19. (a) 11-25- (b) Mr. J. J. Brennan
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Jackson

(c) City or town Grandview, Mo.
(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.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct day 23 1940
year 1940 hour 3 A.M. minute _____ M.

21. I hereby certify that I attended the deceased from May 28, 1940 to Oct 23, 1940;
that I last saw him alive on Oct 20, 1940
and that death occurred on the date and hour stated above.

Immediate cause of death Myocardial infarction Duration 3 mo

Due to arteriosclerosis indolent

Due to _____

Other conditions HTA
(include pregnancy within 3 months of death)

Major findings: _____

Of operations _____

Of autopsy _____

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? 3/6

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

23. Signature B. F. Brennan (M. D. or other) _____

Address Marion City Date signed 10-24-40

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 *A. K. George*

Licensed Embalmer No. *3645*

P. O. Address *Grandview, 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, fact should be so stated above.