

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

18828

State File No.

Registrar's No. 115

Primary Registration District No. 3056

1. PLACE OF DEATH:

(a) County Randolph
 (b) City or town Moberly
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
Wabash 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..... 38 years (Specify whether
 years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Randolph
 (c) City or town Moberly
 (If outside city or town limits, write "RURAL")
 (d) Street No. 525 W. Carpenter
 (If rural, give location)
 (e) Citizen of foreign country?..... (Yes or No)
 If yes, name country.....

3. (a) PRINT FULL NAME Fred W. Phelan

3. (b) If veteran, name war..... 3. (c) Social Security No. 702-05-9140

4. Sex male 5. Color or race White 6. (a) Single, widowed, married, divorced. 9

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

7. Birth date of deceased: April 11th 1887
 (Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>56</u>	<u>1</u>	<u>7</u> hr. min.

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

10. Usual occupation Switchman

11. Industry or business Wabash R.R.

12. Name Fred Phelan

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

14. Maiden name Annie Goodfellow

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

16. (a) Informant Mrs F. W. Phelan

(b) Address Moberly Mo

17. (a) Burial (b) Date thereof May 19th 1943
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Moberly Mo

18. (a) Signature of funeral director Mahan and Son

(b) Address Moberly

19. (a) 5-20-43 (b) Lina Haver
 (Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 18th
 year 1943 hour 6 minute 16 a. m.

21. I hereby certify that I attended the deceased from May 16, 1943, to May 18, 1943;
 that I last saw him alive on May 18, 1943;
 and that death occurred on the date and hour stated above.

Immediate cause of death Cholecystitis

Duration June 2 1942

Due to.....

Due to.....

Other conditions (Include pregnancy within 3 months of death) 127a²

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? X (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? X

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

23. Signature R. D. Street (M. D. or other) Med.

Address Moberly, Mo. Date signed May 20/43

MOTHER, FATHER

JUN 1 1943

8761 LNR

RECEIVED

District Health Officer No. 10

District File Number 5-43-941

Date Filed MAY 28 1943

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 Frank B. DeWitt

Licensed Embalmer No. 3021

P. O. Address Moberly, 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.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

56-12-10

State File No. _____

Registration District No. 294 Primary Registration District No. _____ Registrar's No. _____

1. PLACE OF DEATH:

(a) County Randolph

(b) City or town Moberly
(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 FRED W THELAN

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex M 5. Color or race W

6. (a) Name of husband or wife Wife Thelan 6. (a) Single, widowed, married, divorced Mar.

6. (c) Age of husband or wife if alive 5 years

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

8. AGE: Years 52 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) [Signature]
(Date received local registrar) (Registrar's signature)

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) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month MAY Year 1943
minute 16.0 M.

21. I hereby certify that I attended the deceased from _____ 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 _____ (M. D. or other) _____
Address _____ Date signed _____

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

WHITE PLAINLY—USE UNFADING BLACK INK—MAK A PERMANENT RECORD

SUPPLEMENTARY

S-18829