

ED JUL 14 1943
Registration District No. 73

Primary Registration District No. 3014

1. PLACE OF DEATH:

(a) County CLAY
(b) City or town LIBERTY
(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 _____ (Specify whether _____)
years, months or days

3. (a) PRINT FULL NAME JOHN DAVID FERRIL

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

4. Sex M 5. Color or race Wh 6. (a) Single, widowed, married, divorced. WIDOWED
6. (b) Name of husband or wife SALLIE MEARS 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased Aug. 18, 1859 (Month) (Day) (Year)

8. AGE: Years 83 Months 10 Days 11 If less than one day _____ hr. _____ min.

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

10. Usual occupation FARMER

11. Industry or business

12. Name Lemuel P. Ferril
13. Birthplace Kearney Mo (City, town, or county) (State or foreign country)
14. Maiden name MARY CAREY
15. Birthplace Kearney Mo (City, town, or county) (State or foreign country)

16. (a) Informant CLARENCE FERRIL
(b) Address LIBERTY, MO.

17. (a) BURIAL (Burial, cremation, or removal) (b) Date thereof JUNE 25, 1943 (Month) (Day) (Year)

(c) Place: burial or cremation KEARNEY MO

18. (a) Signature of funeral director Charles E. Early

(b) Address Liberty, Mo

19. (a) 6-24-43 (Date received local registrar) (b) Helen Early (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County CLAY
(c) City or town KEARNEY (If outside city or town limits, write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month JUNE day 24 year 1943 hour 6:00 minute _____ A. M.

21. I hereby certify that I attended the deceased from Sept 10, 1942 to June 16, 1943

that I last saw him alive on June 15, 1943 and that death occurred on the date and hour stated above.

Immediate cause of death Arteriosclerosis of heart causing long duration Duration _____

Due to Arteriosclerosis & Myocardial Infarction

Due to _____

Other conditions _____ (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? _____

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

23. Signature R. E. Berven (M. D. or other) MD
Address Liberty Mo Date signed 6-24-43

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

MOTHER FATHER

926

RECEIVED

District Health Officer No. 8,

District File Number.....

Date Filed

7-13-43

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 *Paul D. Church*

Licensed Embalmer No. *3286*

P. O. Address *Liberty, 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

State File No. *July*
Registrar's No. *0-0*

Registration District No. *73* Primary Registration District No. *3014*

1. PLACE OF DEATH:

(a) County *Clay Liberty*
(b) City or town *Liberty*
(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

John David Feneel

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 *w*

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

7. Birth date of deceased *Aug 18*
(Month) (Day) (Year)

8. AGE: Years *83* Months *10* Days _____ If less than one day _____ min.

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

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER { 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 _____
(Burial, cremation, or removal) (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 _____ (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 _____
year *1943* hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____;
that I last saw him _____, 19____;
and that death occurred on the date and hour stated above.
Immediate cause of death _____ Duration _____

Due to *Chronic Bright Disease with Acute Anemia.*

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

Major findings: Of operations _____ *1318*
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? _____

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

23. Signature *R E Series* (M. D. or other) _____

Address *Liberty Mo* Date signed _____

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

SUPPLEMENTARY

S-2111