

FILED NOV 20 1943  
318

Registration District No. \_\_\_\_\_

Primary Registration District No. 1003

Registrar's No. 9682

1. PLACE OF BIRTH:

(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:  
Childrens Hospital  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 8 hours 0  
In this community Life (Specify whether  
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County \_\_\_\_\_  
(c) City or town St. Louis  
(If outside city or town limits, write "RURAL")  
(d) Street No. 4264, Norfolk  
(If rural, give location)  
(e) Citizen of foreign country? No (Yes or No)  
If yes, name country. \_\_\_\_\_

3. (a) PRINT FULL NAME Donald Wayne Feltz

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

4. Sex M 5. Color or race W 6. (a) Single, widowed, married, divorced Single

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

7. Birth date of deceased 9 28 1933  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
10 1 6 \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace St. Louis Missouri  
(City, town, or county) (State or foreign country)

10. Usual occupation Student

11. Industry or business \_\_\_\_\_

MOTHER FATHER { 12. Name Rainey Feltz  
13. Birthplace Crowford County, Missouri  
(City, town, or county) (State or foreign country)  
14. Maiden name Golda Miller  
15. Birthplace Wolf Lake, Illinois  
(City, town, or county) (State or foreign country)

16. (a) Informant Ruth Rowlan  
(b) Address 1473 Engeholm

17. (a) Burial (b) Date thereof 11/6/43  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Lake Charles

18. (a) Signature of funeral director A. W. McLaughlin  
(b) Address 2301, Lafayette

19. (a) NOV 4 1943 (b) J. F. Bredek  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 11 day 4  
year 43 hour 1 minute 35 A.M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_;  
that I last saw h \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_;  
and that death occurred on the date and hour stated above.

Immediate cause of death \_\_\_\_\_

Septicemia

Due to \_\_\_\_\_

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)

23. Signature W. H. Perry (M. D. or other) \_\_\_\_\_  
Address 1014 1/2 W. 11th Date signed 11/7/43

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

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**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.....

*L. R. Cooper*

Licensed Embalmer No. *3633*

P. O. Address *2317 Lafayette*

**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.**