

FILED AUG 8 1944  
 318

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

Primary Registration District No. 1003

Registrar's No. 6679

1. PLACE OF DEATH:  
 (a) County St. Louis  
 (b) City or town St. Louis  
(If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution: BARNES HOSPITAL  
(If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution. 5 DAYS  
(Specify whether)  
 In this community 5 DAYS  
years, months or days

2. USUAL RESIDENCE OF DECEASED:  
 (a) State Missouri (b) County Scott  
 (c) City or town Benton Mo.  
(If outside city or town limits, write "RURAL")  
 (d) Street No. Rural  
(If rural, give location)  
 (e) Citizen of foreign country? no (Yes or No)  
 If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME ADAM FELTER  
 3. (b) If veteran, name war no  
 3. (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 rosa  
 6. (c) Age of husband or wife if alive 55 years  
 7. Birth date of deceased Jan. 20 1888  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
56 6 9 \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace Kelso Mo.  
(City, town, or county) (State or foreign country)  
 10. Usual occupation Farmer

11. Industry or business \_\_\_\_\_  
 12. Name Alois Felter  
 13. Birthplace Germany  
(City, town, or county) (State or foreign country)  
 14. Maiden name Mary T. Halter  
 15. Birthplace Scott Co. Mo.  
(City, town, or county) (State or foreign country)

16. (a) Informant Sylvester Felter  
 (b) Address Benton Mo.

17. (a) Burial Removal (b) Date thereof 8-1-1944  
(Burial, cremation, or removal) (Month) (Day) (Year)  
 (c) Place: burial or cremation Stape Girardeau Mo.

18. (a) Signature of funeral director W. Schumacher  
 (b) Address 3013 Myranck  
 19. (a) JUL 21 1944 (b) J. F. Brudeck  
(Date received local health officer's certificate) (Registrar's signature)

MEDICAL CERTIFICATION  
 20. DATE OF DEATH: Month July day 29  
 year 1944 hour 9:45 minute FA. M.  
 21. I hereby certify that I attended the deceased from July 24, 1944, to July 29, 1944  
 that I last saw him alive on July 29, 1944  
 and that death occurred on the date and hour stated above.  
 Immediate cause of death \_\_\_\_\_  
 Duration \_\_\_\_\_

Due to Tuberculosis meningitis / Pulmonary Tuberculosis 1 mo.  
 Due to \_\_\_\_\_  
 Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

PHYSICIAN  
 Major findings: \_\_\_\_\_  
 Of operations \_\_\_\_\_  
 Of autopsy confirm spine  
 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) (Means of injury)  
 23. Signature Walter D. Anthony (M.D. or other)  
 Address BARNES HOSPITAL Date signed 7-29-44

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

MOTHER FATHER

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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 Francis A Williamson

Licensed Embalmer No. 3565

P. O. Address St. Louis, 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.