

FILED OCT 6 1944

State File No. _____

Registration District No. 134

Primary Registration District No. 4771

Registrar's No. 61

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

1. PLACE OF DEATH:

(a) County Holt

(b) City or town Mound City
(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) 1

(d) Length of stay: In hospital or institution _____ (Specify whether _____)
In this community _____ (Specify whether _____)
years, months or days

3. (a) PRINT FULL NAME Wanda June Feil

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

4. Sex Female race white 5. Color or _____

6. (a) Single, widowed, married, divorced, single 6. (a) 0

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

7. Birth date of deceased June 6 1939
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day

5	2	27	hr. min.
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9. Birthplace St. Joseph Mo.
(City, town, or county) (State or foreign country)

10. Usual occupation _____

11. Industry or business _____

12. Name H.R. Feil

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

14. Maiden name Margaret Colwell

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

16. (a) Informant H.R. Feil
(b) Address Mound City Mo.

17. (a) Burial (b) Date thereof 9 5 1944
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Mt. Hope

18. (a) Signature of funeral director James H. Pettigrove

(b) Address Mound City, Mo.

19. (a) 9-5-44 (b) Pauline Dawson
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County 44

(c) City or town Mound City
(If outside city or town limits, write "RURAL") 0

(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 Sept day 3rd
year 1944 hour _____ minute 30 A.M.

21. I hereby certify that I attended the deceased from May 11
1944 to Sept 3 1944
that I last saw her alive on Sept 2 1944
and that death occurred on the date and hour stated above.

Immediate cause of death Emphysema Duration 2 Wks

Due to Chronic Bronchitis

Due to _____ 4 months

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 Dr. Perry (M.D. or other) MD
Address Mound City Mo Date signed 9-4-44

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 James H. Pettigrew
Licensed Embalmer No. 31692
P. O. Address Oregon 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.