V. S. No. 2
50M—5-42
Rev. 5-17-39
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED AUG 9 1945

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 25162

Registration District No. 324 Primary Registration District No. 3072 Registrar's No. 109

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

1. PLACE OF DEATH:
(a) County Saline
(b) City or town Marshall
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Fitzgibbons hospital 0
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 3 days (Specify whether
In this community all her life
years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo. (b) County Saline 97
(c) City or town Slater 2
(If outside city or town limits, write "RURAL")
(d) Street No. 1
(If rural, give location)
(e) Citizen of foreign country? yes (Yes or No) 0
If yes, name country

3. (a) PRINT FULL NAME Helen Elizabeth Fellers
3. (b) If veteran, name war no
3. (c) Social Security No. none
4. Sex felmale
5. Color or race white
6. (a) Single, widowed, married, divorced married
6. (b) Name of husband or wife Harry Fellers
6. (c) Age of husband or wife if alive 57 years
7. Birth date of deceased July (Month) 25 (Day) 1903 (Year)

8. AGE: Years 41 Months 11 Days 25 If less than one day ..... hr. ..... min.

9. Birthplace Saline County (City, town, or county) Mo. 0 (State or foreign country)
10. Usual occupation housewife
11. Industry or business
FATHER
12. Name Geo. Inspruckner
13. Birthplace (City, town, or county) Mo. 0 (State or foreign country)
MOTHER
14. Maiden name Annie Shellenberg
15. Birthplace (City, town, or county) Mo. 0 (State or foreign country)
16. (a) Informant Geo. Inspruckner, Jr.
(b) Address R.F.D. Slater, Mo.
17. (a) burial (Burial, cremation, or removal) (b) Date thereof 7-22-45 (Month) (Day) (Year)
(c) Place: burial or cremation Slater, Mo.
18. (a) Signature of funeral director Hill Brothers,
(b) Address Slater, Mo.
19. (a) 7-21-45 (Date received local registrar) (b) Mrs T. Westbrook (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 20th year 1945 hour 12 minute 10 a M.
21. I hereby certify that I attended the deceased from April 5th 1945, to July 20th 1945 that I last saw her alive on July 20 1945 and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Cerebral Embolism	4 hrs
Surgical Shock	10 hrs
Pulmonary Edema	2 1/2
Chronic Fibromyoma	3 hrs

Due to
Due to
Other conditions (Include pregnancy within 3 months of death) 83 P
Major findings: Of operations Fibromyoma Cancer?
Of autopsy None

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) None
(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? (Specify type of place)
While at work? (e) Means of injury
23. Signature [illegible] (M. D. or other)
Address Slater Mo Date signed 7-21-45

1215

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. [illegible]
[illegible] File Number
8-8-45

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 A. C. Hill

Licensed Embalmer No. 3090

P. O. Address Slater, 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.