

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **28437**

FILED SEP 15 1945

Registration District No. **27**

Primary Registration District No. **3070**

Registrar's No. **2203**

1. PLACE OF DEATH:

(a) County **ST LOUIS**
(b) City or town **WEBSTER GROVES**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
447 BELLEVIEW AVE. 1
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether)
In this community **7 YRS**
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State **MO** (b) County **ST LOUIS 91**
(c) City or town **WEBSTER GROVES 7**
(If outside city or town limits, write "RURAL")
(d) Street No. **447 BELLEVIEW 4**
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No) **0**
If yes, name country _____

3. (a) PRINT FULL NAME **MARY ELLEN FEAGIN**

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

4. Sex **FEMALE** 5. Color or race **W** 6. (a) Single, widowed, married, divorced **MARRIED**
6. (b) Name of husband or wife **LAWRENCE BAKER FEAGIN** 6. (c) Age of husband or wife if alive **45** years
7. Birth date of deceased **JAN 12 1901**
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
44	7	27	hr. min.

9. Birthplace **HARTFORD KY 1**
(City, town, or county) (State or foreign country)

10. Usual occupation **HOUSEWIFE**

11. Industry or business **AT HOME**

MOTHER FATHER { 12. Name **JOHN THOMAS MOORE**
13. Birthplace **HARTFORD KY 1**
(City, town, or county) (State or foreign country)
14. Maiden name **MARY ANNE ROSS**
15. Birthplace **HARTFORD KY 1**
(City, town, or county) (State or foreign country)

16. (a) Informant **Mrs. Feagin Col. CF.**
(b) Address **447 Belleview Ave.**

17. (a) **BURIAL** (b) Date thereof **SEPT 11 1945**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **OAK HILL CEMETERY**

18. (a) Signature of funeral director **Parson High Co.**
(b) Address **Webster Groves Mo.**

19. (a) **9-12-45** (b) **Dr. D. S. Dorman**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Sept** day **9th**
year **45** hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from **August 7**, 1945, to **Sept 9**, 1945, that I last saw her alive on **Sept 8**, 1945, and that death occurred on the date and hour stated above.

Immediate cause of death **Carcinoma of ovary 15 Mo.**

Due to **4900**

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations **irreparable carcinoma of ovary**
Of autopsy _____

Duration

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 **H. H. ...** Date signed **9/19/45**
Address: **192 Jackson**

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

WEDNESDAY
MAY 19 1954

WEDNESDAY
MAY 19 1954

MARY ELLEN FEAM

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 *Leslie Welch*

Licensed Embalmer No. 4395

P. O. Address *Robert Groves*

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.