

STANDARD CERTIFICATE OF DEATH

State File No. **36470**

FILED NOV 30 1945

Registration District No. 1

Primary Registration District No. 200 4001

Registrar's No. 9

1. PLACE OF DEATH:

(a) County Adair
(b) City or town Novinger
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Novinger
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____
(Specify whether _____)
In this community _____
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Adair
(c) City or town Kirksville,
(If outside city or town limits, write "RURAL")
(d) Street No. 1008 S. Franklin
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Clara M. Marks Felker

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

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

6. (b) Name of husband or wife George Felker 6. (c) Age of husband or wife if alive 69 years

7. Birth date of deceased Nov. 23 1874
(Month) (Day) (Year)

8. AGE: Years 70 Months 10 Days 3 If less than one day _____ hr. _____ min.

9. Birthplace Adair county Mo.
(City, town, or county) (State or foreign country)

10. Usual occupation Home

11. Industry or business _____

12. Name Samuel Marks

13. Birthplace unknown Ind.
(City, town, or county) (State or foreign country)

14. Maiden name Mary Jennings

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

16. (a) Informant George Felker

(b) Address Kirksville, Mo.

17. (a) Forest Burial (b) Date thereof 9/28/45
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Forest Cemetery

18. (a) Signature of funeral director [Signature]

(b) Address Kirksville, Mo.

19. (a) 10-6-45 (b) [Signature]
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept day 26 year 1945 hour 3:00 minute 0 P. M.

21. I hereby certify that I attended the deceased from Sept 26 1945, to Sept 26 1945.
that I last saw her alive on Sept 26 and that death occurred on the date and hour stated above.

Immediate cause of death Heart stopped
Coronary Thrombosis
Myocardial infarction
Due to age, atherosclerosis
hypertension
Due to Heart stopped before I saw her
Other conditions (Include pregnancy within 3 months of death) _____

Duration

PHYSICIAN

Major findings: Of operations _____
Of autopsy none

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 [Signature] (M. D. or other) _____
Address Novinger, Mo. Date signed 10/3/45

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

RECEIVED

District Health Officer No. 10

District File Number 11-45-178

Date Filed NOV 27 1945

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 *D. E. Riley*.....

Licensed Embalmer No. *4181*.....

P. O. Address: *Hicksville*.....

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.