

No. 2
2-45
17-39
X47370

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

27070

State File No.

FILED SEP 15 1947

Registration District No. 63

Primary Registration District No. 2254

Registrar's No. 26

1. PLACE OF DEATH: **Chariton**

(a) County Tripllett (Rural)

(b) City or town (If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: 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 (Specify whether)

years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Chariton ²¹

(c) City or town Tripllett (Rural) ³

(If outside city or town limits, write "RURAL")

(d) Street No. (If rural, give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3. (a) PRINT **Alfred Feitz**
FULL NAME

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

4. Sex M 5. Color or race White

6. (a) Single, widowed, married, divorced, Married

6. (b) Name of husband or wife Bettie Feitz 6. (c) Age of husband or wife if alive, years

7. Birth date of deceased June 5th 1894

(Month) (Day) (Year)

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

63 2 12 hr. min.

9. Birthplace Mt. Pleasant Iowa

(City, town, or county) (State or foreign country)

10. Usual occupation Farmer

11. Industry or business

12. Name Chris Feitz

13. Birthplace Switzerland

(City, town, or county) (State or foreign country)

14. Maiden name Elizabeth Schiffman

15. Birthplace Switzerland

(City, town, or county) (State or foreign country)

16. (a) Informant Mrs Bettie Feitz

(b) Address Tripllett Mo. R F D

17. (a) Burial (b) Date thereof 8/19/47

(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Newcomer

18. (a) Signature of funeral director S. Shepard

(b) Address Mendon Mo

19. (a) Aug-19-47 (b) Wm. J. ...

(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug. day 17th

year 1947 hour 6 minute A M.

21. I hereby certify that I attended the deceased from Aug 14

....., 1947 to Aug 16, 1947

that I last saw her alive on Aug 16, 1947; and that death occurred on the date and hour stated above.

Immediate cause of death Apoplexy

Due to hypertension long standing

cerebral hemorrhage 3 attack

Due to

Other conditions (Include pregnancy within 3 months of death)

Duration

10 year

PHYSICIAN

Underline the cause to which death should be charged statistically.

Major findings: apoplexy

Of operations

Of autopsy

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) (c) Means of injury

23. Signature J. R. ... (M. D. or other)

Address Brinsford Mo Date signed Aug 18/47

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

MOTHER FATHER

RECEIVED

District Health Officer No. 87

District File Number

Date Filed 9-12-47

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. L. Shepard

Licensed Embalmer No. 397

P. O. Address.....

Mendon M

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.