

FILED SEP 9 1947

Registration District No. 360

Primary Registration District No. 6225

Registrar's No. 146

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

1. PLACE OF DEATH:

(a) County Berman
(b) City or town Great Washington Sup.
(c) Name of hospital or institution: State Hospital # 3
(d) Length of stay: In hospital or institution 19 10 17 days
In this community 1 year 10 months 1 day

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Jasper
(c) City or town Joplin
(d) Street No. _____
(e) If foreign born, how long in U. S. A.? _____ years.

3. (a) PRINT FULL NAME William Oscar FEATHERINGILL

8. (b) If veteran, name war _____ 8. (c) Social Security No.

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

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

7. Birth date of deceased 2-4-1883
(Month) (Day) (Year)

8. AGE: Years 64 Months 6 Days 25 If less than one day _____ hr. _____ min.

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

10. Usual occupation _____

11. Industry or business _____

12. Name John Featheringill

13. Birthplace West Plains Mo
(City, town, or county) (State or foreign country)

14. Maiden name Ann

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

16. (a) Informant Hospital record
(b) Address Nevada, Mo.

17. (a) Burial (b) Date thereof 9-1-47
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Mt. Hope Cemetery
18. (a) Signature of funeral director Parker-Hunsaker
(b) Address 1502 Joplin, Joplin, Mo.
19. (a) 9-2-47 (b) Waltham James
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug day 29
year 1947 hour 10 minute 15 a.m.

21. I hereby certify that I attended the deceased from 7-11-1947 to 8-29-1947
that I last saw him alive on Aug 29 1947
and that death occurred on the date and hour stated above.

Immediate cause of death Acute Endo-Carditis

Due to Meningoencephalitis
febrilis

Due to _____
Other condition Acute Rheum.
(Include pregnancy within 3 months of death)

PHYSICIAN
Major findings: Of operations 30 B
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? _____

23. Signature R. G. Hall (Specify type of place) _____
Address Nevada Mo (c) Means of injury _____
Date signed 8-29-47

RECEIVED
District Health Officer No. 2
8-47-1050
District File Number 9-8-47
Date Filed

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 F. M. Jones

Licensed Embalmer No. 2319

P. O. Address Joplin 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, above space should be left blank.