

FILED SEP 9 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 27757

BIRTH NO. _____ REG. DIST. NO. 310 PRIMARY REG. DIST. NO. 3058 Registrar's No. 156

1. PLACE OF DEATH a. COUNTY <u>St. Charles</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Mo</u> b. COUNTY <u>St. Charles</u>	
b. CITY (If outside corporate limits, write RURAL and give town) <u>St. Charles</u>		c. CITY (If outside corporate limits, write RURAL and give township) <u>O'Fallon Rural</u>	
c. LENGTH OF STAY (In this place) <u>100 days</u>		d. STREET ADDRESS (If rural, give location) _____	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>St. Joseph St. Charles</u>			
3. NAME OF DECEASED a. (First) <u>Anna</u>		b. (Middle) _____	
c. (Last) <u>Feise</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>August 13-49.</u>	
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>May 14 1865</u>
9. AGE (In years last birthday) <u>84</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housework</u>	11. BIRTHPLACE (State or foreign country) <u>St. Peters Mo.</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. NAME OF HUSBAND OR WIFE <u>Joseph Feise deceased</u>	
13a. FATHER'S NAME <u>Ohmes</u>		13b. MOTHER'S MAIDEN NAME <u>Halter</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>no</u>	
17. INFORMANT'S SIGNATURE OR NAME <u>Colette Feise O'Fallon Mo.</u>		ADDRESS _____	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, ashenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Carcinoma of breast</u> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>generalized arteriosclerosis</u> DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT SUICIDE HOMICIDE (Specify) _____		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____	
21c. (CITY, TOWN, OR TOWNSHIP) _____ (COUNTY) _____ (STATE) _____			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____ m.		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR _____			
22. I hereby certify that I attended the deceased from <u>June 19 47</u> to <u>13 Aug, 1949</u> , that I last saw the deceased alive on <u>13 July, 1949</u> , and that death occurred at <u>12:25 P.M.</u> , from the causes and on the date stated above.			
23a. SIGNATURE <u>Lawrence Behun MD.</u>		23b. ADDRESS <u>O'Fallon Mo.</u>	
23c. DATE SIGNED <u>8-27-49</u>			
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>Aug. 16-49</u>	
24c. NAME OF CEMETERY OR CREMATORY <u>Immaculate Conception</u>		24d. LOCATION (City, town, or county) <u>Dardenne Mo.</u>	
DATE REC'D BY LOCAL REG. <u>9-2-49</u>		REGISTRAR'S SIGNATURE <u>Kamie Zambuto</u>	
25. FUNERAL DIRECTOR'S SIGNATURE <u>Earl Kettly</u>		ADDRESS <u>O'Fallon Mo</u>	

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

District File Number _____
District Health Officer No. 9,
RECEIVED
SEP 6 1948

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 _____

_____ Student Embalmer No. _____
working under my personal supervision.

Signed _____
Student Embalmer

Signed E. Keithy
Licensed Embalmer No. 877
P. O. Address Fallon 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.