

FILED MAY 29 1950

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATHState File No. **16442**BIRTH NO. \_\_\_\_\_ REG. DIST. NO. **128** PRIMARY REG. DIST. NO. **2000** Registrar's No. **493**

|   |  |  |  |
|---|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>GREENE</b>  |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).<br>a. STATE <b>MISSOURI</b> b. COUNTY <b>GREENE</b> |  |
| b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>SPRINGFIELD</b> |  | c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>ROGERSVILLE RURAL</b>                                      |  |
| c. LENGTH OF STAY (In this place) <b>30 MIN.</b>  |  | d. STREET ADDRESS (If rural, give location) <b>0390</b>  |  |
| d. FULL NAME OF HOSPITAL OR INSTITUTION <b>BURGE HOSP.</b>                                      |  |  |  |

|   |                                  |  |   |  |   |
|---|----------------------------------|--|---|--|---|
| 3. NAME OF DECEASED<br>(Type or Print)<br>a. (First) <b>WILLIAM</b> b. (Middle) <b>THOMAS</b> c. (Last) <b>FELTON</b>       |                                  |  | 4. DATE OF DEATH<br>(Month) (Day) (Year)<br><b>MAY 25, 1950</b> |  |   |
| 5. SEX<br><b>MALE</b>   | 6. COLOR OR RACE<br><b>WHITE</b> | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)<br><b>MARRIED</b> | 8. DATE OF BIRTH<br><b>NOV. 12, 1891</b>                        | 9. AGE (In years last birthday)<br><b>58</b>                       | IF UNDER 1 YEAR<br>Months <b>6</b> Days <b>13</b> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>FILLING STATION OPER.</b> |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>FILLING STATION</b>              |   | 11. BIRTHPLACE (State or foreign country)<br><b>GREENE CO. MO.</b> |   |
| 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.</b>   |                                  |  | 13a. FATHER'S NAME<br><b>SAMUEL MILTON FELTON</b>               |  |   |
| 13b. MOTHER'S MAIDEN NAME<br><b>SARAH E. HAGGARD</b>  |                                  |  | 14. NAME OF HUSBAND OR WIFE<br><b>PEARL</b>                     |  |   |

|   |  |   |  |   |  |
|---|--|---|--|---|--|
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br><b>NO</b>   |  | 16. SOCIAL SECURITY NO.<br><b>NONE</b>  |  | 17. INFORMANT'S SIGNATURE OR NAME<br><b>MRS. PEARL FELTON</b> |  |
| 18. CAUSE OF DEATH<br>Enter only one cause per line for (a), (b), and (c)<br><br>*This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death. |  | MEDICAL CERTIFICATION<br>I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>probably coronary occlusion</b><br><br>ANTECEDENT CAUSES<br>Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last.<br><br>DUE TO (b) _____<br><br>DUE TO (c) _____<br><br>II. OTHER SIGNIFICANT CONDITIONS<br>Conditions contributing to the death but not related to the disease or condition causing death. |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>4201</b>               |  |

|  |  |  |  |  |  |
|--|--|--|--|--|--|
| 19a. DATE OF OPERATION                             |  | 19b. MAJOR FINDINGS OF OPERATION<br><b>UNATTENDED BY A PHYSICIAN</b>                                   |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input 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 19 to 19, that I last saw the deceased alive on 19, and that death occurred at 7:05 PM, from the causes and on the date stated above.

|  |  |   |  |  |  |
|--|--|---|--|--|--|
| 23a. SIGNATURE<br><b>W. J. Handley</b> |  | Local Registrar of (Specify)<br><b>Vital Statistics</b> |  | 23b. ADDRESS<br><b>City Hall Springfield Mo.</b> |  |
| 23c. DATE SIGNED<br><b>5/27-50</b>     |  |   |  |  |  |

|   |  |                               |  |  |  |
|---|--|-------------------------------|--|--|--|
| 24a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>BURIAL</b>              |  | 24b. DATE<br><b>MAY 28 50</b> |  | 24c. NAME OF CEMETERY OR CREMATORY<br><b>WHITE OAK, CEM.</b> |  |
| 24d. LOCATION (City, town, or county) (State)<br><b>WEBSTER CO. MO.</b> |  |                               |  |  |  |

|  |  |   |  |   |  |
|--|--|---|--|---|--|
| DATE REC'D BY LOCAL REG.<br><b>5-27-50</b> |  | REGISTRAR'S SIGNATURE<br><b>W. J. Handley</b> |  | 25. FUNERAL DIRECTOR'S SIGNATURE<br><b>Kelley-Jurill-Bryson</b> |  |
|  |  |   |  | ADDRESS<br><b>Rogersville Mo.</b>                               |  |

(Licensed Embalmer's Statement on Reverse Side)

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

**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 Th. K. Kelly

Signed.....  
Student Embalmer

Licensed Embalmer No. 3334

P. O. Address fordland 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.