No. 300
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THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 6992

BIRTH NO. _____ REG. DIST. NO. 336 PRIMARY REG. DIST. NO. 6131 Registrar's No. 165

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

1. PLACE OF DEATH
a. COUNTY: Shannon
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Montier Mo
c. LENGTH OF STAY (In this place): 5 Years
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): None

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Missouri
b. COUNTY: Shannon
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Montier Missouri 1010
d. STREET ADDRESS (If rural, give location): 0

3. NAME OF DECEASED (Type or Print)
a. (First): Albert
b. (Middle): Henry
c. (Last): Fellers

4. DATE OF DEATH (Month) (Day) (Year): Feb 10th 1952

5. SEX: M
6. COLOR OR RACE: W
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: Nov 23rd 1885
9. AGE (In years last birthday): 66 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Pittsburg Pa
12. CITIZEN OF WHAT COUNTRY?: USA

13a. FATHER'S NAME: William Fellers
13b. MOTHER'S MAIDEN NAME: Belle Landis
14. NAME OF HUSBAND OR WIFE: Elizabeth Fellers

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO — (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: 169-01-2497
17. INFORMANT'S SIGNATURE OR NAME: Elizabeth Fellers — **ADDRESS**: Montier Mo

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, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Apoplexy — INTERVAL BETWEEN ONSET AND DEATH:

ANTECEDENT CAUSES — *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.*
DUE TO (b): arterial tension
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: 334X
20. AUTOPSY? YES ☐ NO ☒

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 ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?:

22. *I hereby certify that I attended the deceased from* Dec 15, 1950, *to* Feb 10, 1952, *that I last saw the deceased alive on* Feb 5, 1952, *and that death occurred at* 3 a m., *from the causes and on the date stated above.*

23a. SIGNATURE: R. L. Davis (Degree or title): M.D.
23b. ADDRESS: Birch Tree Mo
23c. DATE SIGNED: 3/9-52

24a. BURIAL, CREMATION, REMOVAL (Specify): 0
24b. DATE: Feb 13 52
24c. NAME OF CEMETERY OR CREMATORY: Corinth
24d. LOCATION (City, town, or county) (State): Birch Tree Mo

DATE REC'D BY LOCAL REG.: 3-10-52
REGISTRAR'S SIGNATURE: Mabel Reeves 447
25. FUNERAL DIRECTOR'S SIGNATURE: Donna J. N. — **ADDRESS**: Mt View Mo

(Licensed Embalmer's Statement on Reverse Side)

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.

Student .....
Student Embalmer

Signed Joe R. Duncan

Licensed Embalmer No. 4325

P. O. Address Mt Vernon 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.