THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

22347

State File No.

FILED JUL 1 - 1953

BIRTH NO. REG. DIST. NO. 265 PRIMARY REG. DIST. NO. 3896 Registrar's No. 8

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1. PLACE OF DEATH
a. COUNTY: Ozark
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Noble, R, Noble
c. LENGTH OF STAY (In this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location):

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Missouri
b. COUNTY: Douglas
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Noble Rural, Noble
d. STREET ADDRESS (If rural, give location): 0370 1

3. NAME OF DECEASED (Type or Print)
a. (First): James
b. (Middle): C.
c. (Last): Feemster

4. DATE OF DEATH (Month) (Day) (Year): 3-28-53

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Never married
8. DATE OF BIRTH: 7-29-69
9. AGE (In years last birthday): 83 — If under 1 year: Months, Days — If under 24 hrs.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work doneduring most of working life, even if retired): Farming
10b. KIND OF BUSINESS OR INDUSTRY: Own home
11. BIRTHPLACE (City and State or Foreign Country): Decatur, Ill.
12. CITIZEN OF WHAT COUNTRY?: USA

13a. FATHER'S NAME: Samuel Feemster
13b. MOTHER'S MAIDEN NAME: Sovira Robertson
14. NAME OF HUSBAND OR WIFE:

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.: None
17. INFORMANT'S SIGNATURE OR NAME: J Royce Feemster — **ADDRESS**: Wasola 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) Accidental burned on own farm while burning brush

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

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INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION

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20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify): Accident
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): Farm
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE): Douglas Missouri

21d. TIME OF INJURY (Month) (Day) (Year) (Hour): 3-28-53 2:P.m.
21e. INJURY OCCURRED WHILE AT WORK ☒ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?: While burning brush

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 2:P m., from the causes and on the date stated above.

23a. SIGNATURE: Geo. A Rose (Degree or title) acting Coroner
23b. ADDRESS: Gainesville Mo.
23c. DATE SIGNED: 4-1-53

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 3-21-53
24c. NAME OF CEMETERY OR CREMATORY: Davis
24d. LOCATION (City, town, or county) (State): Noble, Missouri

DATE REC'D BY LOCAL REG.: 6-26-53
REGISTRAR'S SIGNATURE: Mae Johnson
25. FUNERAL DIRECTOR'S SIGNATURE **ADDRESS**: 243- Clinkingbeard Funeral Home, Ava, Mo.

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USING UNFADING INK

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 Charles A. Fish

Licensed Embalmer No. 4662

P. O. Address Ava, Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.