

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **27097**

FILED JUL 23 1953

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. **317** PRIMARY REG. DIST. NO. **541** Registrar's No. **1923**

1. PLACE OF DEATH a. COUNTY <b>ST LOUIS</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>MISSOURI</b> b. COUNTY <b>ST LOUIS</b>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>CLAYTON</b>		c. CITY OR TOWN <b>OVERLAND 23<sup>4</sup></b>	
c. LENGTH OF STAY (in this place) <b>30 DAYS</b>		d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>ST LOUIS Co Hospital</b>		e. STREET ADDRESS (If rural, give location) <b>9128 SHELLEY</b>	
3. NAME OF DECEASED (Type or Print) a. (First) <b>Thomas</b> b. (Middle) <b>Augustine</b> c. (Last) <b>Feary</b>			4. DATE OF DEATH (Month) (Day) (Year) <b>July 10 1953</b>
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>MARRIED</b>	8. DATE OF BIRTH <b>MAY 19 1906</b>
9. AGE (In years last birthday) <b>47</b>		10. IF UNDER 1 YEAR Months _____ Days _____	10. IF UNDER 24 HRS. Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>TRUCK DRIVER</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>HAULING</b>	11. BIRTHPLACE (City and State or Foreign Country) <b>TUXEDO PARK, MISSOURI</b>	12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
13a. FATHER'S NAME <b>AUGUSTINE FEARY</b>	13b. MOTHER'S MAIDEN NAME <b>MAX FLYME</b>	14. NAME OF HUSBAND OR WIFE <b>MABEL FEARY</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>	16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <b>490-05-0471</b>	17. INFORMANT'S SIGNATURE OR NAME ADDRESS <b>MABEL FEARY 9128 SHELLEY</b>	
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.			INTERVAL BETWEEN ONSET AND DEATH <b>2 wks -</b>
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>ENCEPHALITIS, Etio. UNKNOWN</b>			
ANTECEDENT CAUSES Morbidity 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.			
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input checked="" 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)	<b>343X</b>
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)	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 <b>7-8</b> , 19 <b>53</b> , to <b>7-10</b> , 19 <b>53</b> , that I last saw the deceased alive on <b>7-10</b> , 19 <b>53</b> , and that death occurred at <b>2:55 Am.</b> , from the causes and on the date stated above.			
23a. SIGNATURE (Degree or title) <b>Robert Hein M.D.</b>		23b. ADDRESS <b>6015 Brentwood, Clayton 5, Mo</b>	23c. DATE SIGNED <b>7-10-53</b>
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	24b. DATE <b>7/13/53</b>	24c. NAME OF CEMETERY OR CREMATORY <b>LAKE CHARLES PARK</b>	24d. LOCATION (City, town, or county) (State) <b>WELLSTON MISSOURI</b>
DATE REC'D BY LOCAL REG. <b>7-13-53</b>	REGISTRAR'S SIGNATURE <b>Herbert R. Domba M.D.</b>	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>EARL HILLMAN OVERLAND MISSOURI</b>	

(Licensed Embalmer's Statement on Reverse Side)

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

40020

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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.....  
Signature of Student Embalmer

Signed *Eve L. Hillman*.....

Licensed Embalmer No. *3501*.....  
P. O. Address *Orestand, Missouri*.....

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.