

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **40055**

FILED DEC 7 1953

BIRTH NO. _____ REG. DIST. NO. **310** PRIMARY REG. DIST. NO. **3000** Registrar's No. **10**

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1. PLACE OF DEATH a. COUNTY St. Charles		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY St. Charles	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Charles	c. LENGTH OF STAY (in this place) 13 yrs.	c. CITY OR TOWN St. Charles	d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION St. Joseph Hospital		e. STREET ADDRESS (If rural, give location) 336 Monroe Ave.	

3. NAME OF DECEASED (Type or Print) Julius		a. (First)	b. (Middle)	c. (Last) Feist	4. DATE OF DEATH Nov. 29, 1953		(Month)	(Day)	(Year)
5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH Unknown	9. AGE (In years last birthday) Ab. 71	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	IF UNDER 24 HRS. Hours	IF UNDER 24 HRS. Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retailer		10b. KIND OF BUSINESS OR INDUSTRY Window Trimming		11. BIRTHPLACE (City and State or Foreign Country) Germany 4		12. CITIZEN OF WHAT COUNTRY? USA			

13a. FATHER'S NAME Solomon Feist		13b. MOTHER'S MAIDEN NAME Johanna Unknown		14. NAME OF HUSBAND OR WIFE Lucie Feist	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY (If yes, give war or dates of service) 491-26-258		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Abe Hess St. Charles, Mo.	

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)		MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH 4 years	
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Carcinoma of Sigmoid		ANTECEDENT CAUSES none		DUE TO (b)	
*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.		DUE TO (c)	
II. OTHER SIGNIFICANT CONDITIONS Arteriosclerosis		Conditions contributing to the death but not related to the disease or condition causing death.		?	

19a. DATE OF OPERATION 1948		19b. MAJOR FINDINGS OF OPERATION Carcinoma of Sigmoid 153 X		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 building, etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)	
21d. TIME OF INJURY: (Month) (Day) (Year) (Hour)		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 **Dec 10, 1949** to **Nov 29, 1953**, that I last saw the deceased alive on **Nov 29, 1953** and that death occurred at **3:00** p. m., from the causes and on the date stated above.

23a. SIGNATURE [Signature] (Degree or title) MD		23b. ADDRESS St Charles, Mo		23c. DATE SIGNED Nov 29, 1953	
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24a. BURIAL, CREMATION, REMOVAL (Specify) Removal		24b. DATE 12/1/1953		24c. NAME OF CEMETERY OR CREMATORY B'nai Amoona Ceme.		24d. LOCATION (City, town, or county) (State) University City, Mo.	
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DATE REC'D BY LOCAL REG. Nov 30 1953		REGISTRAR'S SIGNATURE 284-0 Franice Hamilton		FUNERAL DIRECTOR'S SIGNATURE ADDRESS Boeger Memorial 4715 McPherson Ave.	
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St. Louis Mo

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

OCT 22 1958

OCT 8 1958

OCT 8 1958

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 *Quinn J. Quiring*.....

Licensed Embalmer No. *4329*.....

P. O. Address.....

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.