

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **41830**

FILED DEC 8 1953

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. **337** PRIMARY REG. DIST. NO. **4496** Registrar's No. **10201**

0020

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

1. PLACE OF DEATH a. COUNTY <b>Shelby</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>Mo</b> b. COUNTY <b>Shelby</b>	
b. CITY (If outside corporate limits, write RURAL and give township) <b>Shelbyville</b>		c. CITY (If outside corporate limits, write RURAL and give township) <b>Shelbyville</b>	
c. LENGTH OF STAY (in this place) <b>Life</b>		d. STREET ADDRESS (If rural, give location)	
d. FULL NAME OF HOSPITAL OR INSTITUTION <input checked="" type="checkbox"/>			

3. NAME OF DECEASED (Type or Print)	a. (First) <b>Charles</b>	b. (Middle) <b>R.</b>	c. (Last) <b>Feely</b>	4. DATE OF DEATH (Month) (Day) (Year) <b>Nov 11 - 1953</b>
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5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Widowed</b>	8. DATE OF BIRTH <b>Aug 7 1874</b>	9. AGE (In years) (Month) (Day) (Min.) <b>79 - 3 4</b>
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY <b>Retired</b>	11. BIRTHPLACE (State or foreign country) <b>Shelby County Mo</b>	12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>
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13a. FATHER'S NAME <b>James L. Feely</b>	13b. MOTHER'S MAIDEN NAME <b>Mattie E. Morrison</b>	14. NAME OF HUSBAND OR WIFE <b>Lillian Hollenbeck</b>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO. <input checked="" type="checkbox"/>	17. INFORMANT'S SIGNATURE OR NAME <b>Mrs. Mabel Gaines</b>	ADDRESS <b>Shelbyville Mo</b>
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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, asthma, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		19. INTERVAL BETWEEN ONSET AND DEATH <b>5 days</b>
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Coronary Occlusion</b>		
	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.			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION <b>4201</b>	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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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)
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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?
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22. I hereby certify that I attended the deceased from **Nov 6**, 1953, to **Nov 11**, 1953, that I last saw the deceased alive on **Nov 11**, 1953, and that death occurred at **9:35 a.m.**, from the causes and on the date stated above.

23a. SIGNATURE <b>H. C. Brewer M.D.</b> (Degree or title)	23b. ADDRESS <b>Shelbyville Mo</b>	23c. DATE SIGNED <b>Nov 12 - 53</b>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	24b. DATE <b>Nov 13 - 1953</b>	24c. NAME OF CEMETERY OR CREMATORY <b>I.O.O.F. Cemetery</b>	24d. LOCATION (City, town, or county) (State) <b>Shelbyville Mo</b>
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DATE REC'D BY LOCAL REG. <b>Dec 15 53</b>	REGISTRAR'S SIGNATURE <b>Ada Garrison</b>	419	25. FUNERAL DIRECTOR'S SIGNATURE <b>E. P. Thompson</b>	ADDRESS <b>Shelbyville Mo</b>
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DEC 14

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.....

..... *Myself* .....

working under my personal supervision.

Student Embalmer No.....

Signed..... *E. P. Thompson* .....

Signed.....  
Student Embalmer

Licensed Embalmer No. *1632*

P. O. Address *Shelbyville 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.