

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-009219

STATE FILE NUMBER

FILED MAR 24 1959

Registration District No. 141 Primary Registration District No. 3025 Registrar's No. 24

300  
-57

1. PLACE OF DEATH a. COUNTY <u>HOWELL</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MO-</u> b. COUNTY <u>OREGON</u>	
b. CITY OR TOWN (If outside corporate limits, give TOWNSHIP only) <u>WEST PLAINS</u>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>ALTON</u> <u>07.50</u>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>WEST PLAINS MEM. HOSP.</u>		Length of stay in 1b	d. STREET ADDRESS (If outside, give location) <u>ROUTE # 2</u>
Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			

3. NAME OF DECEASED (Type or print) First Middle Last <u>ANNA G. FELDMANN</u>			4. DATE OF DEATH Month Day Year <u>3 13 1959</u>		
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5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1-18-1891</u>	9. AGE (In years last birthday) <u>68</u>	IF UNDER 1 YEAR Months Days <u>1 25</u>	IF UNDER 24 HRS. Hours Min. <u>1 25</u>
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	11. BIRTHPLACE (City and state or country) <u>MILWAUKEE, WIS-</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.-</u>
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13a. FATHER'S NAME <u>JOHN GEBHART</u>	13b. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>	14. NAME OF HUSBAND OR WIFE <u>FRANK FELDMAN, DEC-</u>
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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. <u>356-14-7519</u>	17. INFORMANT Address
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>LARYNGO SPASM &amp; CARDIAC ARREST</u>		INTERVAL BETWEEN ONSET AND DEATH <u>5 min.</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>Surgical Shock</u>	<u>7 min</u>
	DUE TO (c) <u>Abdominal Exploration</u>	<u>1 hour</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal condition given in PART I (a) <u>INTESTINAL OBSTRUCTION (BEZOAR)</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>

20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) <u>—</u>
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20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m. <u>—</u>	<u>9230</u> <u>22</u>
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20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>—</u>	20f. CITY, TOWN, OR LOCATION <u>—</u>	COUNTY <u>075</u>	STATE
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21. I attended the deceased from <u>3:20 P.M.</u> - <u>10-59</u> , to <u>3-13-59</u> and last saw her <sup>her</sup> alive on <u>3-13-59</u> Death occurred at <u>3:20 P.M.</u> m on the date stated above; and to the best of my knowledge, from the causes stated.
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22a. SIGNATURE <u>Frank Wiles, M.D.</u>	(Degree or title)	22b. ADDRESS <u>West Plains, Mo.</u>	22c. DATE SIGNED <u>3-16-59</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>CREMATION</u>	23b. DATE <u>3-22-1959</u>	23c. NAME OF CEMETERY OR CREMATORY <u>THOMPSON BRO-S-</u>	23d. LOCATION (City, town, or county) (State) <u>MEMPHIS TENN-</u>
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24. FUNERAL DIRECTOR <u>John Clay Cotton, M.D.</u>	ADDRESS <u>—</u>	25. DATE RECD. BY LOCAL REG. <u>3-18-59</u>	26. REGISTRAR'S SIGNATURE <u>Beatrice Cook</u>
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(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

All diseases in Part I must be causally related.

79

MAR 27 1959

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 *John D. Churg* .....

Licensed Embalmer No. *4475*  
P. O. Address *Box 398 alt*

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.