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THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

59-013277

STATE FILE NUMBER 1914

FILED MAY 13 1959 Registration District No. 149 Primary Registration District No. 1002 Registrar's No.

1. PLACE OF DEATH
a. COUNTY JA CKSON
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN KANSAS CITY — Inside Limits Yes [X] No [ ]
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION D.O.A. RESEARCH — Length of stay in 1b 28 yrs.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE MISSOURI b. COUNTY JACKSON
c. CITY OR TOWN KA NSA S CITY — Inside Limits Yes [X] No [ ]
d. STREET ADDRESS 5138 AGNES (If outside, give location) — Reside on Farm Yes [ ] No [X]

3. NAME OF DECEASED (Type or print) First JOHN Middle S. Last FEIBER

4. DATE OF DEATH Month APRIL Day 16, Year 1959

5. SEX MALE

6. COLOR OR RACE WHITE

7. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]

8. DATE OF BIRTH 2 11 1901

9. AGE (In years last birthday) 58 — IF UNDER 1 YEAR Months Days — IF UNDER 24 HRS Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Truck Drive Elite Cleaners

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (City and state or country) St. Louis, Mo.

12. CITIZEN OF WHAT COUNTRY? U. S. A.

13a. FATHER'S NAME Joseph ~~Fieber~~ Feiber

13b. MOTHER'S MAIDEN NAME Anna Deckelmann

14. NAME OF HUSBAND OR WIFE MARJORIE FEIBER

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. 487 09 4644

17. INFORMANT MRS. MARJORIE FEIBER-KANSAS CITY, MISSOURI Address 5128 AGNES

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Acute Myocardial Infarction	½ hour
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b)	Arteriosclerotic Heart Disease	6 months.
DUE TO (c)		

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 4200

19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]

20a. ACCIDENT [ ] SUICIDE [ ] HOMICIDE [ ]

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year

20d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]

20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

20f. CITY, TOWN, OR LOCATION COUNTY STATE

21. I attended the deceased from 4-11-59, to 4-16-59 and last saw him alive on 4-14-59
Death occurred at 11:30 P.m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE William G. Eubank (Degree or title) MD.

22b. ADDRESS Roytown Clinic Missouri

22c. DATE SIGNED 4-17-59

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial

23b. DATE April 18, 1959

23c. NAME OF CEMETERY OR CREMATORY Mt Moriah

23d. LOCATION (City, town, or county) (State) Kansas City, Mo

24. FUNERAL DIRECTOR 1331 BRUSH CREEK BLVD. (Address) D. W. NEWCOMER'S SONS-KANSAS CITY, MO.

25. DATE RECD. BY LOCAL REG. 4-17-59

26. REGISTRAR'S SIGNATURE Neva Minshall

William Y. Eubank USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

Antecedent diseases in Part I must be causally related.

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalme

by me, or by ....., Student Embalmer No. .....

working under my personal supervision.

Student .....
Signature of Student Embalmer

Signed Vern Fowler

Licensed Embalmer No.....

P. O. Address.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failu 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.