

FEDERAL DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-031724

FILED VS SEP 13 1960

Registration District No. 310 Primary Registration District No. 3058 Registrar's No. 177

STATE FILE NUMBER

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, give TOWNSHIP only) OR TOWN St. Charles		Length of stay in 1b	c. CITY OR TOWN O'Fallon
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Joseph Hospital		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) R. R. #2
		Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First Anton Middle Feise Last Feise			4. DATE OF DEATH Month September Day 2 Year 1960			
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5. SEX Male	6. COLOR OR RACE White	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH Oct. 10, 1872	9. AGE (last birthday) 87	IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>	IF UNDER 24 HR Hours <input type="checkbox"/> Min. <input type="checkbox"/>
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farming	10b. KIND OF BUSINESS OR INDUSTRY Farming	11. BIRTHPLACE (City and state or country) St. Charles County, Mo	12. CITIZEN OF WHAT COUNTRY USA
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13a. FATHER'S NAME Joseph Feise	13b. MOTHER'S MAIDEN NAME Magdalena Weichens	14. NAME OF HUSBAND OR WIFE Lessie S. Feise
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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) No	16. SOCIAL SECURITY NO. None	17. INFORMANT Barney Feise, RR #2 O'Fallon, Mo.
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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) Uremia		INTERVAL BETWEEN ONSET AND DEATH 3 weeks	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) Fracture intertrochanteric hip		6 weeks
	DUE TO (c) Senility		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	

19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input checked="" 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.) Fall at home
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20c. TIME OF INJURY Hour 4:05 a.m. PM Month, Day, Year July 17 '60
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20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Home	20f. CITY, TOWN, OR LOCATION O'Fallon	COUNTY St. Charles	STATE Mo.
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21. I attended the deceased from **July 17, 1960** to **Sept 2, 1960** and last saw him alive on **Sept 2, 1960**
Death occurred at **4:05 PM** on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) Russell Feider M.D.	22b. ADDRESS St Charles, Mo	22c. DATE SIGNED Sept 5 '60
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23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE Sept. 6, 1960	23c. NAME OF CEMETERY OR CREMATORY St. Paul Cemetery	23d. LOCATION (City, town, or county) St. Paul, Missouri
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24. FUNERAL DIRECTOR Keithly Funeral Home, O'Fallon, Mo	25. DATE RECD. BY LOCAL REG. Sept 5-60	26. REGISTRAR'S SIGNATURE Marcella Wilson
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DOCUMENT
MEDICAL CERTIFICATION
BY AFFIDAVIT OF

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed David C. Bane

Licensed Embalmer No. 5060

P.O. Address St. Charles

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.