

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

66 0049507

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 137 Primary Registration District No. 3023 Registrar's No. 351

FILED DEC 27 1966

VS 300
Rev. 4/59

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

USE BLACK INK OR TYPEWRITER RIBBON

| | | | |
|---|---|---|---|
| 1. PLACE OF DEATH a. COUNTY <u>Henry</u> | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Henry</u> | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) <u>Clinton</u> | | c. CITY OR TOWN <u>Clinton Township</u> | |
| Length of stay in 1b <u>Years</u> | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Clinton General Hosp</u> | | d. STREET ADDRESS (If outside, give location) <u>RFD 5, Clinton</u> | |
| Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | | Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Middle Last <u>MAY BOWERS FEASTER</u> | | | 4. DATE OF DEATH Month Day Year <u>December 16, 1966</u> |
| 5. SEX <u>Female</u> | 6. COLOR OR RACE <u>White</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>11/15/86</u> |
| 9. AGE (last birthday) <u>80</u> | | IF UNDER 1 YEAR Months Days | IF UNDER 24 HR Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>At home</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>none</u> | 11. BIRTHPLACE (City and state or country) <u>Fonda, Iowa</u> |
| 13a. FATHER'S NAME <u>William Bowers</u> | | 13b. MOTHER'S MAIDEN NAME <u>Jane Higgins</u> | 14. NAME OF HUSBAND OR WIFE <u>Rafe Feaster, Deceased</u> |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u> | | 16. SOCIAL SECURITY NO. <u>None</u> | |
| 17. INFORMANT <u>Marguerite Feaster, Clinton, Mo.</u> | | Address | |
| 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>Conjunctive Heart Failure</u> | | | INTERVAL BETWEEN ONSET AND DEATH <u>8 days</u> |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Myocardial infarction</u> | | | <u>6 weeks</u> |
| DUE TO (c) <u>Generalized arteriosclerosis</u> | | | <u>6-7 yrs</u> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Cerebral ischemia</u> | | | PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown |
| 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.) | |
| 20c. TIME OF INJURY Hour a.m. p.m. | 20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | |
| 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 <u>June 6, 1966</u> to <u>Dec 16, 66</u> and last saw ^{her} alive on <u>Dec 15, 66</u> Death occurred at <u>Clinton, Mo</u> <u>5:30 A</u> m on the date stated above, and to the best of my knowledge, from the causes stated. | | | |
| 22a. SIGNATURE <u>James O. Smith M.D.</u> (Degree or title) | | 22b. ADDRESS <u>Clinton - Mo</u> | 22c. DATE SIGNED <u>12-17-66</u> |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | 23b. DATE <u>Dec 18, 1966</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>Laurel Oak</u> | 23d. LOCATION (City, town, or county) (State) <u>Windsor, Missouri</u> |
| 24. FUNERAL DIRECTOR <u>Consalus</u> ADDRESS <u>Clinton, Mo.</u> | | 25. DATE RECD. BY LOCAL REG. <u>Dec 19, 1966</u> | 26. REGISTRAR'S SIGNATURE <u>Mildred Bigum</u> |

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 Eugene R. Conoalun

Licensed Embalmer No. 4680

P. O. Address Clinton, 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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.

Permit Obtained 12-19-66
MB