

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-62-032186

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

STATE FILE NUMBER

DO NOT WRITE
ON THIS STUB

AMENDED

Registration District No. 316 Primary Registration District No. 3059 Registrar's No. 373

FILED AUG 28 1962

1. PLACE OF DEATH a. COUNTY St Francois		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY St Francois	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Bonne Terre Mo.		c. CITY OR TOWN Farmington	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Bonne Terre Hosp.		d. STREET ADDRESS (If outside, give location) 313 W College	
3. NAME OF DECEASED (Type or print) First Middle Last Joseph H Feezor		4. DATE OF DEATH Month Day Year Aug. 21 1962	
5. SEX Male	6. COLOR OR RACE White	7. Married ☒ Never Married ☐ Widowed ☐ Divorced ☐	8. DATE OF BIRTH 1/18/89
9. AGE (last birthday) 73		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer	
11. BIRTHPLACE (City and state or country) St Francois County Mo U S A		12. CITIZEN OF WHAT COUNTRY U S A	
13a. FATHER'S NAME James Feezor		13b. MOTHER'S MAIDEN NAME Anna Jones	
14. NAME OF HUSBAND OR WIFE Jennie Cowley Feezor		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes WW-1	
16. SOCIAL SECURITY NO.		17. INFORMANT Mrs Jennie Feezor Farmington Mo.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH 1 day
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. ☐ Yes ☐ No ☐ Unknown
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒	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 July 1962 and last saw him alive on Aug 21/62		Death occurred at 11 p.m. on the date stated above, and to the best of my knowledge, from the causes stated.	
22a. SIGNATURE (Degree or title) Oliver Karakur MD		22b. ADDRESS Farmington, MO	
22c. DATE SIGNED 8/23/62		23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	
23b. DATE 8/24/62		23c. NAME OF CEMETERY OR CREMATORY Hillview Memorial	
23d. LOCATION (City, town, or county) Farmington		23e. STATE Missouri	
24. FUNERAL DIRECTOR C.H.COZEAN FARMINGTON MO.		25. DATE RECD. BY LOCAL REG. Aug 23, 1962	
26. REGISTRAR'S SIGNATURE Ester Rudloff			

(Licensed Embalmer's Statement on Reverse Side)

USE BLACK INK
OR
TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

DOCUMENT

BY AFFIDAVIT OF

DATE AMENDED

VS 300
Rev. 4/59

10941

20945

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AUG 29 1962

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 _____

Ch Cozear

Licensed Embalmer No. _____

4084

P. O. Address _____

Farmington 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.