S. No. 2
DM—2-43
v. 5-17-39
I X35697

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

FILED NOV 8 1945

State File No. 34498

Registration District No. 316 Primary Registration District No. 6075 Registrar's No. 188

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:
(a) County St. Francois
(b) City or town rural St. Francois
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution
In this community lifetine (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo (b) County St. Francois
(c) City or town rural
(If outside city or town limits, write "RURAL")
(d) Street No.
(If rural, give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME W. M. Feezor
3. (b) If veteran, name war
3. (c) Social Security No.
4. Sex m
5. Color or race w
6. (a) Single, widowed, married, divorced m
6. (b) Name of husband or wife Magalime Potter Feezor
6. (c) Age of husband or wife if alive 61 years
7. Birth date of deceased 10-12-1882 (Month) (Day) (Year)

8. AGE: Years	Months	Days	If less than one day
63		2	hr. min.

9. Birthplace Farmington, (City, town, or county) Mo (State or foreign country)
10. Usual occupation Farmer
11. Industry or business Farming
FATHER
12. Name Jamrs M. Feezor
13. Birthplace Tenn (City, town, or county) (State or foreign country)
MOTHER
14. Maiden name Sarah Jones
15. Birthplace (City, town, or county) Kentucky (State or foreign country)
16. (a) Informant Jack Feezor
(b) Address Farmington
17. (a) b (Burial, cremation, or removal) (b) Date thereof 10-16-45 (Month) (Day) (Year)
(c) Place: burial or cremation K of P. Farmington
18. (a) Signature of funeral director C. [illegible]. Cozean
(b) Address Farmington
19. (a) 10-15-45 (Date received local registrar) (b) Esther Rudloff (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month October day 14 year 1945 hour 8 minute a. M.
21. I hereby certify that I attended the deceased from June 1, 1944 to Oct 14, 1945
that I last saw him alive on Oct. 14, 1945
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral arteriosclerosis — Duration
Due to
Due to
Other conditions
(Include pregnancy within 3 months of death)
Major findings:
Of operations
Of autopsy

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify)
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?
(Specify type of place)
While at work? (e) Means of injury
23. Signature [illegible] (M. D. or other) MD
Address [illegible] No 4 Date signed 10-15-45

1591

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 4
District File Number 1145-1319
Date Filed 11-8-45

NOV 17 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 ...., Registered Apprentice No. ...., working under my personal supervision.

Signed C H Cozean

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 this body is not embalmed, fact should be so stated above.