

**MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH**

Do not use this space.

38928

1. PLACE OF DEATH
 County Crawford Registration District No. 233
 Township Primary Registration District No. 5318
 City (No.) St. Ward)

2. FULL NAME Leah R. Ferguson
 (a) Residence. No. Leasburg Mo. St. Ward.
 (Usual place of abode) (If nonresident give city or town and State)
 Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

File No.
 Registered No. 218

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M. 4. COLOR OR RACE W. 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Lydia Louise Ferguson

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Jan 28 - 1874

7. AGE YEARS MONTHS DAYS IF LESS than I day, hrs. or min.
56 1 28

8. OCCUPATION OF DECEASED
 (a) Trade, profession, or particular kind of work farming
 (b) General nature of industry, business, or establishment in which employed (or employer)
 (c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) Kent-Indiana Co. Perma
 (STATE OR COUNTRY)

10. NAME OF FATHER Joseph Ferguson

11. BIRTHPLACE OF FATHER (CITY OR TOWN) Indiana Co. Perma
 (STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER Margaret Clawson

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Indiana Co. Perma
 (STATE OR COUNTRY)

14. INFORMANT Caroline Massey
 (Address) Leasburg Mo.

15. Dec 2 30 H. F. Truman M.D.
 FILED 19

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 12/1 1930

17. I HEREBY CERTIFY That I attended deceased from Nov 10, 1930, to Dec 1, 1930, that I last saw him alive on Dec 1, 1930, and that death occurred, on the date stated above, at 1 a. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Tuberculosis of the lungs
2 3/4 (duration) 2 yrs. mos. da.

CONTRIBUTORY Tubercular Kidney
 (SECONDARY) (duration) 2 yrs. mos. da.

18. WHERE WAS DISEASE CONTRACTED
 IF NOT AT PLACE OF DEATH? no

DID AN OPERATION PRECEDE DEATH? no DATE OF

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS? Clinical
 (Signed) H. F. Truman, M. D.

see (Address) Leasburg Mo.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Leasburg Cemetery DATE OF BURIAL 12/2 1930

20. UNDERTAKER L. J. Jones Steelville Mo.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

WRITE PLAINLY, WITH UNFADING INK

