

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

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

39678
Do not use this space.

REC'D DEC 1 1939
074

1. PLACE OF DEATH
 (a) County Brunswick Registration District No. 327
 (b) Township _____ Primary Registration District No. 4194
 or _____
 (c) City Galt (d) Street No. _____ St.
 (If death occurred in Hospital or Institution, write its name instead of street and number)
 (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME Mrs. Georgenna Ferson
 (a) Residence, No. _____ St. (If nonresident, give city or town and State)
 (Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX female 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) widowed

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF J. S. Ferson

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Jan 1. 1873

7. AGE YEARS MONTHS DAYS IF LESS than 1 day,hrs. ormin.
66 10 17

OCCUPATION
 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.
 9. Industry or business in which work was done, as saw mill, bank, etc. Housewife
 10. Date deceased last worked at this occupation (month and year) _____ 11. Total time (years) spent in this occupation _____

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Clarke Co. Mo

FATHER
 13. NAME Joseph DeGelia
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) N. Y.

MOTHER
 15. MAIDEN NAME _____
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Saratoga, W. Va.

17. INFORMANT Mrs M W Williams
 (ADDRESS) Laredo Mo

18. BURIAL, CREMATION, OR REMOVAL
 PLACE Humphreys DATE Nov 21 1939

19. FUNERAL DIRECTOR (NAME) (ADDRESS) PK Parnett
Galt Mo

20. FILED 11-19-39 E. C. Weston
 Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Nov 18 19 39

22. I HEREBY CERTIFY, That I attended deceased from Nov 1938 to Nov 18 1939
 I last saw her alive on Nov 18 1939. Death is said to have occurred on the date stated above, at 11:30 A.M.
 The principal cause of death and related causes of importance were as follows:
T. B. of Lungs
73

Date of onset _____

Other contributory causes of importance: _____

Name of operation _____ Date of _____
 What test confirmed diagnosis? _____ Was there an autopsy? Y

23. If death was due to external causes (violence), fill in also the following:
 Accident, suicide, or homicide? _____ Date of injury: _____, 19 _____
 Where did injury occur? _____ (Specify city or town, county, and State)
 Specify whether injury occurred in industry, in home, or in public place. _____

Manner of injury _____
 Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased? no
 If so, specify _____
 (Signed) A. C. Brown, M. D.
Galt Mo (Address)

RECEIVED

District Health Officer No. 11,

District of Columbia

1239-1764

DEC 18 1939

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.....

Licensed Embalmer No.....

P. O. Address.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to conform with the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.