

Registration District No. 791

Primary Registration District No. 1003

Registrar's No.

1. PLACE OF DEATH:

(a) County _____
 (b) City or town St Louis
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
Homer G Phillips
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 12 days
(Specify whether)
 In this community 9 years
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County _____
 (c) City or town St Louis 22
(If outside city or town limits, write "RURAL")
 (d) Street No. 2616 Spruce
(If rural, give location)
 (e) If foreign born, how long in U. S. A. _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 17
 year 1940 hour 9:33 minute _____ A. M.
 21. I hereby certify that I attended the deceased from
July 6, 1940, to July 17, 1940;
 that I last saw her alive on July 17, 1940;
 and that death occurred on the date and hour stated above.

Immediate cause of death: Tuberculous Meningitis 20 days
 Duration

Due to _____
 Due to _____
 Other conditions: _____
(Include pregnancy within 3 months of death)

PHYSICIAN
 Major findings: _____
 Of operations: _____
 Of autopsy: _____
 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? _____

While at work? _____
(Specify type of place) (e) Means of injury

23. Signature J. W. Johnson (M. D. or other) _____
 Address 2601 N Whittier Date signed _____

3. (a) PRINT FULL NAME Adline Ferguson 622

3. (b) If veteran, name war _____ 3. (c) Social Security No. None

4. Sex Female 5. Color or race Negro 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Robert Ferguson 6. (c) Age of husband or wife if alive 39 years

7. Birth date of deceased Aug 23, 1907
(Month) (Day) (Year)

8. AGE: Years 32 Months 10 Days 24 If less than one day _____ hr. _____ min.

9. Birthplace Miss _____
(City, town, or county) (State or foreign country)

10. Usual occupation House Work

11. Industry or business At Home

12. Name Nathan Mc Kinney

13. Birthplace Mississippi
(City, town, or county) (State or foreign country)

14. Maiden name Smith

15. Birthplace Miss _____
(City, town, or county) (State or foreign country)

16. (a) Informant Robert Ferguson

(b) Address 2616 Spruce St

17. (a) Burial (b) Date thereof 7-20-40
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Shaw, Miss

18. (a) Signature of funeral director Atkins Bros

(b) Address 3644 Finney Ave

19. (a) JUL 20 1940 (b) J. F. Bredek
(Date received local registrar) (Registrar's signature)

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

17-39
X21492

REC AUG 25 1940

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: *Ronnie V. Atkinson*

Licensed Embalmer No. *2842*

P. O. Address *3644 F Street*

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, above space should be left blank.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

State File No. 23639
Registrar's No. 6084

Registration District No. 791

Primary Registration District No. 1003

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

1. PLACE OF DEATH

(a) County St. Louis
(b) City or town St. Louis
(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 _____ (Specify whether
years, months or days)

3. (a) PRINT FULL NAME

Adeline Ferguson
3. (b) If veteran, name war _____
3. (c) Social Security No. _____

4. Sex

Female
5. Color of Black
(a) Single, widowed, married, divorced _____

6. (b) Name

Adeline Ferguson
(c) Age of husband, or wife, if alive _____ years

7. Birth date of deceased

(Month) (Day) (Year)
32 10 24

8. AGE:

Years Months Days If less than one day
32 10 24 hr. min.

9. Birthplace

(City, town, or county) (State or foreign country)

10. Usual occupation

11. Industry or business

12. Name Adeline Ferguson

13. Birthplace (City, town, or county) (State or foreign country)

14. Maiden name (City, town, or county) (State or foreign country)

15. Birthplace (City, town, or county) (State or foreign country)

16. (a) Informant

(b) Address

17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)

(c) Place: burial or cremation

18. (a) Signature of funeral director

(b) Address

19. (a) 12/5/40 (Date received local registrar) (b) J. F. Bredesch (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County _____
(c) City or town _____ (If outside city or town limits write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) If foreign born, how long in U. S. A.? _____ years.

20. DATE OF DEATH

Month 7 day 17
year _____ hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from

_____ 19____ to _____ 19____;
that I last saw him _____ alive on _____ 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death _____

Due to

Due to

Other conditions _____
(Include pregnancy within 3 months of death)

Major findings:

Of operations _____

Of autopsy _____

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? _____

While at work? _____ (Specify type of place)
(c) Means of injury _____

23. Signature J. W. Johnson (M. D. or other) _____

Address _____ Date signed _____

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

SUPPLEMENTARY

