V. S. No. 2
00M—2-43
ev. 5-17-39
1 X35697

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED NOV 4 1944

Registration District No. 1838

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 34524

Primary Registration District No. 3030

Registrar's No. 134

50 3 1

1. PLACE OF DEATH
(a) County Jefferson
(b) City or town Festus
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 401 N. Mill
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 1 (Specify whether years, months or days)
In this community

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Jefferson
(c) City or town Festus (If outside city or town limits, write "RURAL") 50
(d) Street No. 401 N. Mill (If rural, give location) 3 1
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME Glenn Lee Ferguson
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 S
6. (b) Name of husband or wife
6. (c) Age of husband or wife if alive years
7. Birth date of deceased May (Month) 14 (Day) 1943 (Year)
8. AGE: Years 1 Months 2 Days 20 If less than one day hr. min.
9. Birthplace St Louis (City, town, or county) Mo (State or foreign country)
10. Usual occupation Infant
11. Industry or business
MOTHER FATHER
12. Name Orville Ferguson
13. Birthplace Bonne Terre (City, town, or county) Mo (State or foreign country)
14. Maiden name Kathleen Wehner
15. Birthplace Festus (City, town, or county) Mo (State or foreign country)
16. (a) Informant Kathleen Ferguson
(b) Address Festus Mo
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-6-44 (Month) (Day) (Year)
(c) Place: burial or cremation Gamel Cemetery
18. (a) Signature of funeral director Fink Und. Co.
(b) Address Festus Mo
19. (a) Aug. 4, 1944 (Date received by local registrar) (b) Lillye Williams (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug day 4 year 1944 hour 5 minute 45 A.M.
21. I hereby certify that I attended the deceased from July 28, 1944, to Aug 4, 1944, that I last saw him alive on Aug 4, 1944, and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Broncho Pneumonia	1 day
Due to: Whooping cough	5 weeks
Due to:	
Other conditions (Include pregnancy within 3 months of death):	
Major findings: Of operations: None	
Of autopsy: No	

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 Everett Denny M.D. (M.D. or other)
Address Herculaneum, Mo. Date signed 8/9/44

1357

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 9,

District File Number

Date Filed 11-2-44

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 Elevan Province

Licensed Embalmer No. 3403

P. O. Address Festus 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.