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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI

FILED AUG 3 1945

STANDARD CERTIFICATE OF DEATH

21886

State File No.

Registration District No. 212

Primary Registration District No. 100.3

Registrar's No. 6499

1. PLACE OF DEATH:

(a) County.....
(b) City or town St. Louis, Mo.
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: City Hospital
Max Starkloff Memorial
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 5 days
(Specify whether
In this community 0
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County.....
(c) City or town St. Louis
(If outside city or town limits, write "RURAL")
(d) Street No. 1234 1/2 So. 6th Street
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country.....

3. (a) PRINT FULL NAME FERGUSON, ROBERT

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

4. Sex male 5. Color or race white 6. (a) Single, widowed, married, divorced single
6. (b) Name of husband or wife..... 6. (c) Age of husband or wife if alive..... years
7. Birth date of deceased May 10th 1945
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
2 12 hr. min.

9. Birthplace St. Louis Missouri
(City, town, or county) (State or foreign country)

10. Usual occupation None

11. Industry or business - -

MOTHER FATHER
12. Name Oliver
13. Birthplace Oklahoma
(City, town, or county) (State or foreign country)
14. Maiden name Bella
15. Birthplace Missouri
(City, town, or county) (State or foreign country)

16. (a) Informant RaNation
(b) Address City Hospital

17. (a) (Burial, ~~monument or memorial~~) (b) Date thereof 7-26-45
(Month) (Day) (Year)
(c) Place: burial or cremation City Cemetery

18. (a) Signature of funeral director W. J. White
(b) Address City Hospital, No. 1

19. (a) JUL 25 1945 (b) (Registrar's signature)
(Date received local registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 22
year 1945 hour 5:50 minute AM

21. I hereby certify that I attended the deceased from July 18, 1945 to July 22, 1945, 1945
that I last saw him alive on July 22, 1945, 1945
and that death occurred on the date and hour stated above.

Immediate cause of death Older's disease
Prescribed medicine 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?

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

23. Signature Gilbert B. Forke (M. D. or other)
Address 1518 Lafayette Ave. Date signed 7/23/45

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

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 comply with the above constitutes grounds for revocation of license.)

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

Registration District No. 318 818 Primary Registration District No. 1003 1003

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

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:
.....
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution..... (Specify whether
In this community.....
years, months or days)

3. (a) PRINT FULL NAME..... Robert 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.....

6. (b) Name of husband or wife..... 6. (c) Age of husband or wife if alive.....

7. Birth date of deceased..... May 10 1945
(Month) (Day) (Year)

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

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

10. Usual occupation.....

11. Industry or business.....

MOTHER FATHER

12. Name.....

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

14. Maiden name.....

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) AUG 20 1945 (Date received local registrar) J. F. Bredek (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) Citizen of foreign country?..... (Yes or No)
If yes, name country.....

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month..... Aug Year..... 1945 hour..... minute..... M.

21. I hereby certify that I attended the deceased from..... 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)

(e) Means of injury.....

23. Signature..... (M. D. or other).....

Address..... Date signed.....

SUPPLEMENTARY

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

S-21886