

No. 2
-5-43
5-17-39
I X36574

FILED APR 31 1946

Registration District No. 31 Primary Registration District No. 6076

State File No. Registrar's No. 929

1. PLACE OF DEATH:

(a) County St. Louis

(b) City or town Riverview Gardens
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
100 Chambers Road
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 25 years (Specify whether years, months or days)

In this community 25 years

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St. Louis 96

(c) City or town St. Louis Rural 0
(If outside city or town limits, write "RURAL")

(d) Street No. 100 Chambers Road
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country _____

3. (a) PRINT FULL NAME Winifred C. Graves Ferguson

3. (b) If veteran, name war None

3. (c) Social Security No. None

4. Sex Female 5. Color or race White

6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife William S. Ferguson

6. (c) Age of husband or wife if alive 77 yr. years

7. Birth date of deceased Jan. 22, 1873
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	73	2	4	hr. min.

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

10. Usual occupation at Home

11. Industry or business _____

MOTHER FATHER {

12. Name A. D. St Clair

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

14. Maiden name Florence Zukeway

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

16. (a) Informant William S. Ferguson

(b) Address 100 Chambers Road

17. (a) Cremation (b) Date thereof 3/28/46
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Valhalla Crematory

18. (a) Signature of funeral director Mathias Hermann & Son

(b) Address 2161 East Fair Avenue

19. (a) 3-27-46 (b) E. D. Dr. Hansen MD
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 26
year 1946 hour 11 minute 5 PM M.

21. I hereby certify that I attended the deceased from January 12, 1946, to 26 March, 1946.
that I last saw her alive on 25 March, 1946, and that death occurred on the date and hour stated above.

Immediate cause of death Circulatory and Heart Failure Duration 4 mo

Due to Caecemia of Carcinomatous 2 Year

Due to Carcinoma of the Breasts 8 1/2 Year (Rt)
7 Year (Lt)

Other conditions 50
(Include pregnancy within 3 months of death)

PHYSICIAN

Major findings: Carcinoma of Breasts
Of operations: Right 9/5/27 Left 1/9/39 (By Dr. Shurwin)
Of autopsy: None Performed

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. Ernest Jensen (M. D. or other) MD
Address 3700 Washington Blvd. Date signed 3/27/46

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

APR 9 1946

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 *Gustav W. Dietrich*

Licensed Embalmer No. *4329*

P. O. Address *St. Louis, 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.