

No. 2
5-43
17-39
236671

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED OCT 24 1946

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

32623
State File No.

Registration District No. 10 Primary Registration District No. 5036 Registrar's No. 149

1. PLACE OF DEATH:
(a) County Audrain
(b) City or town rural, Wilson
(c) Name of hospital or institution: R.F.D. # Thompson, Mo. /
(d) Length of stay: In hospital or institution 50 years (Specify whether years, months or days)

3. (a) PRINT FULL NAME John A. Ferguson
3. (b) If veteran, name war. No. 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 7 years
7. Birth date of deceased Sept. 7 1856 (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
about 90 1 10 hr. min.

9. Birthplace Virginia (State or foreign country)
retired farmer

10. Usual occupation

11. Industry or business

MOTHER FATHER
12. Name W. Ferguson
13. Birthplace Virginia (State or foreign country)
14. Maiden name Loretta Chadwick
15. Birthplace Virginia (State or foreign country)

16. (a) Informant Rose Tilger
(b) Address R.F.D. Thompson, Missouri

17. (a) burial (b) Date thereof Oct. 19-46 (Month) (Day) (Year)
(c) Place: burial or cremation Thompson Cemetery

18. (a) Signature of funeral director Earl S. Pugh
(b) Address Mexico, Missouri
19. (a) 10-19-1946 (Date received local registrar) (b) Blanche Neely (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Audrain 4
(c) City or town rural 0
(d) Street No. Thompson, Missouri 0 (If rural, give location)
(e) Citizen of foreign country? no (Yes or No) 0
If yes, name country.

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month Oct. day 17
year 1946 hour 1 minute 35 A.M.
21. I hereby certify that I attended the deceased from Oct 17, 1945 to Oct 17, 1945 that I last saw h. I.M. alive on Oct. 17, 1945 and that death occurred on the date and hour stated above.

Immediate cause of death
Myocarditis chro
Due to Senility
Other conditions (Include pregnancy within 3 months of death)
Major findings: Of operations 93D
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 John A. Owen (M. D. or other) Do. Address Mexico Mo. Date signed 10-17-46

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

RECEIVED
District Health Officer No. 10
District File Number 10:46:1936
Filed on OCT 23 1948

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.....

Earl E. Precht.....

Registered Apprentice No.

working under my personal supervision.

Signed.....

Earl E. Precht

Licensed Embalmer No. 3189.....

P. O. Address. Mexico, Missouri.....

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. 10

Primary Registration District No. 5036

1. PLACE OF DEATH:

(a) County Andrew
(b) City or town Rural
(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)

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 _____

3. (a) PRINT FULL NAME

John A. 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 _____

7. Birth date of deceased Sept 7 1900
(Month) (Day) (Year)

8. AGE: Years 90 Months _____ Days _____ If less than one day _____ hr. _____ min.

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

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) _____ (b) Date thereof _____
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) 10/19/46 (b) Blanche Kelly
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month _____ Day _____
Year 1946 Hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ to _____, 19____;
that I last saw him _____ and that death occurred on the date and hour stated above.
Immediate cause of death _____

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 _____ (M. D. or other) _____

Address _____ Date signed _____

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

SUPPLEMENTARY

32623