

FILED DEC 14 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 38704
10364

318

1003

BIRTH NO. _____		REG. DIST. NO. _____		PRIMARY REG. DIST. NO. _____		Registrar's No. _____	
1. PLACE OF DEATH a. COUNTY _____				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY _____			
b. CITY (If outside corporate limits, write RURAL and give town) <u>St Louis</u>		c. LENGTH OF STAY (In this place) <u>9 days</u>		c. CITY (If outside corporate limits, write RURAL and give township) <u>St Louis</u>		d. STREET ADDRESS (If rural, give location) <u>1815 Coleman Street</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Homer G Phillips Hospital</u>							
3. NAME OF DECEASED (Type or Print) a. (First) <u>Joe</u>		b. (Middle) _____		c. (Last) <u>Ferguson</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>November 27, 1949</u>	
5. SEX <u>Male</u>		16. COLOR OR RACE <u>Negro</u>		7. MARRIED, NEVER MARRIED, WIDOWER, DIVORCED, <u>Married</u> (Specify)		8. DATE OF BIRTH <u>June 14, 1909</u>	
9. AGE (In years last birthday) <u>40</u>		IF UNDER 1 YEAR Months <u>5</u> Days <u>13</u>		IF UNDER 24 HRS. Hours _____ Min. _____			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Labor</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Hussmann Ref. Co.</u>		11. BIRTHPLACE (State or foreign country) <u>St. Louis, Mo.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S. A.</u>	
13a. FATHER'S NAME <u>Josiah W. Ferguson Sr.</u>		13b. MOTHER'S MAIDEN NAME <u>Belle Chinn</u>		14. NAME OF HUSBAND OR WIFE <u>Myrtle Ferguson</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>492-10-4996</u>		17. INFORMANT'S SIGNATURE OR NAME <u>Myrtle Ferguson</u> ADDRESS <u>1815 Coleman St.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))				MEDICAL CERTIFICATION			
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Cerebral Thrombosis</u>				INTERVAL BETWEEN ONSET AND DEATH <u>Unk</u>			
*This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.				ANTECEDENT CAUSES			
DUE TO (b) <u>Hypertension</u>				Unk			
DUE TO (c) _____							
II. OTHER SIGNIFICANT CONDITIONS							
Conditions contributing to the death but not related to the disease or condition causing death.							
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify) _____		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____		21c. (CITY, TOWN, OR TOWNSHIP) _____ (COUNTY) _____ (STATE) <u>MO</u>			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>B-22N</u>			
22. I hereby certify that I attended the deceased from <u>11-18-49</u> to <u>11-27-49</u> that I last saw the deceased alive on <u>11-27-49</u> , and that death occurred at <u>9:00 A.M.</u> from the causes and on the date stated above.							
23a. SIGNATURE <u>J. I. Hedrick</u> (Degree or title) <u>M.D.</u>				23b. ADDRESS <u>2601 N Whittier St.</u>		23c. DATE SIGNED <u>11-30-49</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>12-2-49</u>		24c. NAME OF CEMETERY OR CREMATORY <u>St. Peters, St. Louis</u>		24d. LOCATION (City, town, or county) (State) <u>St. Louis, Mo.</u>	
DATE REC'D BY LOCAL _____		REGISTRAR'S SIGNATURE <u>J. B. Basater</u>		25. FUNERAL DIRECTOR'S SIGNATURE _____ ADDRESS <u>4019 Washington</u>			

WRITE PLAINLY—USING 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 _____

Student Embalmer No. _____

working under my personal supervision.

Student _____
Student Embalmer

Signed _____

Licensed Embalmer No. 4371

P. O. Address. St Louis, Mo

Note: The above **MUST BE SIGNED BY THE LICENSED EMBALMER** in his **OWN HANDWRITING**. (Failure to comply the above constitutes grounds for revocation of license.)

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