

FILED JAN 23 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

Dr. John W. Williams

State File No. 797

0396

BIRTH NO. _____ REG. DIST. NO. 128 PRIMARY REG. DIST. NO. 200 Registrar's No. 38

1. PLACE OF DEATH a. COUNTY Greene		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Greene	
b. CITY (If outside corporate limits, write RURAL and give OR TOWN Springfield)		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Springfield	
c. LENGTH OF STAY (for this place) 65 yrs		d. STREET ADDRESS (If rural, give location) 838 W. Walnut St.	
d. FULL NAME OF HOSPITAL OR INSTITUTION 838 West Walnut St.			

3. NAME OF DECEASED (Type or Print) a. (First) George b. (Middle) Washington c. (Last) Ferguson			4. DATE OF DEATH (Month) (Day) (Year) Jan. 13, 50		
5. SEX Male 10	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH April, 4, 1856	9. AGE (In years last birthday) 93	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) retired		10b. KIND OF BUSINESS OR INDUSTRY Photography		11. BIRTHPLACE (State or foreign country) Unknown	
12. CITIZEN OF WHAT COUNTRY U. S. A.					

13a. FATHER'S NAME Isaac Ferguson		13b. MOTHER'S MAIDEN NAME Mary Ellen Harrison		14. NAME OF HUSBAND OR WIFE X	
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. No		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Mr Clarence Ferguson St Louis, Mo	
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Semility ANTECEDENT CAUSES Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.				INTERVAL BETWEEN ONSET AND DEATH	
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19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION			20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
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21a. ACCIDENT SUICIDE HOMICIDE (Specify) No		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) None		21e. INJURY OCCURRED WHILE AT WORK? <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from **Jan 7, 1950**, to **Jan 13, 1950**, that I last saw the deceased alive on **Jan 7, 1950**, and that death occurred at **5:25 P.M.** from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) John W. Williams M.D.		23b. ADDRESS 710 Linden Blk Springfield		23c. DATE SIGNED 1-14-50	
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE 1/16/50		24c. NAME OF CEMETERY OR CREMATORY Maple Park		24d. LOCATION (City, town, or county) (State) Springfield, Missouri	
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DATE REC'D BY LOCAL REG. 1-16-50		REGISTRAR'S SIGNATURE W. E. Handley		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS H. H. Lohmeyer Springfield, Mo	
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

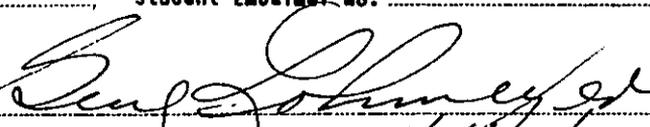
STATEMENT BY LICENSED EMBALMER

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.

Signed.....



Signed.....

Student Embalmer

Licensed Embalmer No. 4734

P. O. Address Springfield, 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.