

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

27301

State File No.

FILED SEP 6 1950

BIRTH NO. _____ REG. DIST. NO. 155 PRIMARY REG. DIST. NO. 3127 Registrar's No. 119

| | | | |
|--|--|---|--|
| 1. PLACE OF DEATH a. COUNTY Jasper | | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Jasper | |
| b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Webb City | | c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Joplin | |
| d. FULL NAME OF HOSPITAL OR INSTITUTION Jane Chinn Hospital | | d. STREET ADDRESS (If rural, give location) 715 Kentucky | |

| | | | | |
|-------------------------------------|----------------------------|---------------------------|------------------------------|--|
| 3. NAME OF DECEASED (Type or Print) | a. (First) Della | b. (Middle) May | c. (Last) Ferguson | 4. DATE OF DEATH (Month) (Day) (Year) August 24 1950 |
|-------------------------------------|----------------------------|---------------------------|------------------------------|--|

| | | | | |
|-------------------------|----------------------------------|--|---|---|
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed | 8. DATE OF BIRTH Dec. 23 1872 | 9. AGE (In years last birthday) Months Days Hours Min. 77 |
|-------------------------|----------------------------------|--|---|---|

| | | | |
|---|--|---|--|
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife | 10b. KIND OF BUSINESS OR INDUSTRY own home | 11. BIRTHPLACE (State or foreign country) Barry County, Mo. | 12. CITIZEN OF WHAT COUNTRY? USA |
|---|--|---|--|

| | | |
|---|---|-----------------------------|
| 13a. FATHER'S NAME Riley Lynn | 13b. MOTHER'S MAIDEN NAME Matilda Oakes | 14. NAME OF HUSBAND OR WIFE |
|---|---|-----------------------------|

| | | | |
|---|-------------------------|--|--|
| 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. | 17. INFORMANT'S SIGNATURE OR NAME Pauline Beeler | ADDRESS 715 Kentucky Joplin Mo |
|---|-------------------------|--|--|

| | | | |
|---|--|--|----------------------------------|
| 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 | | INTERVAL BETWEEN ONSET AND DEATH |
| | I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Broncho pneumonia | DUE TO (b) Hepatogenous jaundice | 4 days |
| ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (c) Septic obstruction of Bile duct | Chronic nephritis | 5 days | 5 days |
| II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Chronic Myocarditis | | several days | 1 year |

| | | |
|------------------------|----------------------------------|---|
| 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) 29212 |
|--|--|---|

| | | |
|--|--|----------------------------|
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 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 9-26, 1949, to 8-24, 1950, that I last saw the deceased alive on 8-24, 1950, and that death occurred at 7:30 P. m., from the causes and on the date stated above.

| | | |
|---|---|------------------------------------|
| 23a. SIGNATURE (Degree or title) H. M. ... D.O. | 23b. ADDRESS 1702 Joplin St. Joplin Mo. | 23c. DATE SIGNED 8-26-50 |
|---|---|------------------------------------|

| | | | |
|--|-----------------------------|--|---|
| 24a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 24b. DATE 8-26-50 | 24c. NAME OF CEMETERY OR CREMATORY Forest Park | 24d. LOCATION (City, town, or county) (State) Joplin, Mo. |
|--|-----------------------------|--|---|

| | | | |
|---|---|--|---------|
| DATE REC'D BY LOCAL REG Aug 26/50 | REGISTRAR'S SIGNATURE S. L. ... | 25. FUNERAL DIRECTOR'S SIGNATURE Parker-Hunsaker Mortuary, Joplin Mo | ADDRESS |
|---|---|--|---------|

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

RECEIVED 9-5-50
Jasper County Health Office

County File Number 50-8-643
Date Filed 9-5-50

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 F. M. Jones

Signed _____
Student Embalmer

Licensed Embalmer No. 2319

P. O. Address Joplin 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.