

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

21973

State File No. _____
Registrar's No. 5292

FILED JUN 27 1952

318

1003

BIRTH NO. _____ REG. DIST. NO. _____ PRIMARY REG. DIST. NO. _____

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

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 township) OR TOWN <u>St. Louis</u>		c. LENGTH OF STAY (In this place) <u>13 months</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>St. Louis</u>			
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Homer G. Phillips Hospital</u>				d. STREET ADDRESS (If rural, give location) <u>27 3107 Laclade Ave.</u>			
3. NAME OF DECEASED (Type or Print) <u>Leo Ferguson</u>			a. (First) _____	b. (Middle) _____	c. (Last) _____		
4. DATE OF DEATH (Month) (Day) (Year) <u>6 7 52</u>							
5. SEX <u>M</u>	6. COLOR OR RACE <u>Col</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>married</u>	8. DATE OF BIRTH <u>May 1, 1925</u>		9. AGE (In years last birthday) <u>27</u>		
f UNDER 1 YEAR _____ g UNDER 1 MONTH _____	h UNDER 1 YEAR _____ i UNDER 1 MONTH _____	j UNDER 1 YEAR _____ k UNDER 1 MONTH _____	l UNDER 1 YEAR _____ m UNDER 1 MONTH _____	n UNDER 1 YEAR _____ o UNDER 1 MONTH _____	p UNDER 1 YEAR _____ q UNDER 1 MONTH _____		
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 _____		11. BIRTHPLACE (State or foreign country) <u>Raines Tenn</u>			
12. COUNTRY OF WHAT COUNTRY? <u>U.S.A.</u>							
13a. FATHER'S NAME <u>Rufus Ferguson</u>		13b. MOTHER'S MAIDEN NAME <u>Amanda Mitchell</u>		14. NAME OF HUSBAND OR WIFE <u>Annie Kattie Ferguson</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>War 2</u>		16. SOCIAL SECURITY NO. <u>415-18-7064</u>		17. INFORMANT'S SIGNATURE OR NAME <u>Margaret Howell</u>			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)		I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>1. Shotgun wound of left groin;</u> (b) <u>2. Pulmonary oedema;</u> (c) <u>3. Ether anesthesia,</u> following injury suffered when shot with shotgun in the hands of one Sylvia Jointer (Col.) in room of home at 3107 Laclade Ave. about 12:35 A.M., June 6, 1952.		INTERVAL BETWEEN ONSET AND DEATH _____			
*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>WHETHER HOMICIDAL, JUSTIFIABLE</u>					
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION <u>OR ACCIDENTAL COULD NOT BE DETERMINED. OPEN VERDICT.</u>		20. AUTOPSY YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT SUICIDE HOMICIDE <u>Verdict</u>		21b. PLACE OF INJURY (a.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) _____		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>E9190-17</u>			
22. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at <u>7:52</u> m., from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) <u>Patrick E. Taylor, M.D.</u>				23b. ADDRESS <u>1300 Clark</u>			
23c. DATE SIGNED <u>6.10.52</u>							
24a. BURIAL, CREMATION, (REMOVAL) <u>Paris, Tenn</u>		24b. DATE <u>6-52</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Spring Field Miss</u>			
24d. LOCATION (City, town, or county) (State) <u>Miss</u>							
DATE REC'D BY LOCAL REG. <u>JUN 10 1952</u>		REGISTRAR'S SIGNATURE <u>J. Carl Smith</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>W. Gus Lowe</u>			
ADDRESS <u>2930 Dickson St.</u>							

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

Arthur L. Hesliard

Licensed Embalmer No. *4221*

P. O. Address *4524 Aldine*

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.