

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **2718**
Registrar's No. **0145**

FILED JAN 26 1954

REG. DIST. NO. **318**

PRIMARY REG. DIST. NO. **1003**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Toledo	
b. CITY OR TOWN St. Louis	c. LENGTH OF STAY (in this place) township) 6 hrs.	c. CITY OR TOWN House Springs	d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>
d. FULL NAME OF HOSPITAL OR INSTITUTION Inc. Word Hospital		e. STREET ADDRESS (If rural, give location) 0507	
3. NAME OF DECEASED a. (First) FERGUS (Type or Print)		b. (Middle) H.	c. (Last) DISHAROON
4. DATE OF DEATH 1-3-54		5. SEX male	
6. COLOR OR RACE white	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) married	8. DATE OF BIRTH 11-22-1879	9. AGE (in years last birthday) 74 if UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) retail clerk	10b. KIND OF BUSINESS OR INDUSTRY hardware	11. BIRTHPLACE (City and State or Foreign Country) Gray Summit, Mo.	12. CITIZEN OF WHAT COUNTRY? USA
13a. FATHER'S NAME Bergus Disharoon Sr.	13b. MOTHER'S MAIDEN NAME Ekka Nunn	14. NAME OF HUSBAND OR WIFE Maud A. Disharoon	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no	16. SOCIAL SECURITY (If yes, give war or dates of service) 494-07-6801A	17. INFORMANT'S SIGNATURE OR NAME ADDRESS Marg. Cooper, House Springs, 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 I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Hemorrhage ANTECEDENT CAUSES Hypertension Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Hypertension DUE TO (c) II. OTHER SIGNIFICANT CONDITIONS Carcinomas 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 checked="" type="checkbox"/> NO <input 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)	
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? 331X	
22. I hereby certify that I attended the deceased from 3:04 1-3-54 , to 11:30 1-3-54 , that I last saw the deceased alive on 1-3-54 , and that death occurred at 8:45 p.m., from the causes and on the date stated above.			
23a. SIGNATURE (Degree or title) Ruslan Dahms MD		23b. ADDRESS 1852 So Grand	23c. DATE SIGNED 1-7-54
24a. BURIAL, CREMATION, REMOVAL (Specify) removal	24b. DATE 1-5-54	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State) House Springs, Mo.
DATE REC'D BY LOCAL REG. JAN 7 1954	REGISTRAR'S SIGNATURE J. Earl Smith MD	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Brimmer F.H., House Springs, Mo	

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

53287

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.....
Signature of Student Embalmer

Signed *Ronald O. Y...*

Licensed Embalmer No. *39*

P. O. Address *Stau*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (to comply with the above constitutes grounds for revocation of license).
If embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.