

FILED APR 14 1955

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **8200**
1298

BIRTH NO. _____ REG. DIST. NO. 149 PRIMARY REG. DIST. NO. 1002 Registrar's No. _____

1. PLACE OF DEATH a. COUNTY Jackson		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Jackson	
b. CITY (If outside corporate limits, write RURAL and give town) Kansas City		c. CITY OR TOWN Kansas City	d. Is Residence within limits of a city incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. LENGTH OF STAY (in this place) 31 yrs		STREET ADDRESS (If rural, give location) 8219 Brooklyn Ave	
d. FULL NAME OF HOSPITAL OR INSTITUTION 8219 Brooklyn Ave			

3. NAME OF DECEASED (Type or Print) a. (First) Clara		b. (Middle) Bell		c. (Last) Ferguson		4. DATE OF DEATH (Month) (Day) (Year) March 23 1955	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed		8. DATE OF BIRTH Jan 2 1877		9. AGE (In years last birthday) 78	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Homemaking		11. BIRTHPLACE (City and State or Foreign Country) Iowa /		12. CITIZEN OF WHAT COUNTRY? U.S.	

13a. FATHER'S NAME Jess Bray		13b. MOTHER'S MAIDEN NAME Sarah Hancock		14. NAME OF HUSBAND OR WIFE John Thomas Ferguson	
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes or unknown) NO (If yes, give war or dates of service) X X X		16. SOCIAL SECURITY NO. NONE		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Mrs. Florence Smith 8219 Brooklyn Ave	
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))		MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Hemorrhage		DUE TO (b) _____					
*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.		DUE TO (c) _____					
II. OTHER SIGNIFICANT CONDITIONS (Conditions contributing to the death but not related to the disease or condition causing death) History from Gen Hosp						3317	

19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE natural		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?	

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 _____ m., from the causes and on the date stated above.

23. SIGNATURE Hugh B. Owens (Degree or title) ³		23b. ADDRESS 1034 Oakto Bldg		23c. DATE SIGNED 3-23-55	
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE 26 March 1955		24c. NAME OF CEMETERY OR CREMATORY Floral Hills	
		24d. LOCATION (City, town, or county) (State) Kansas City Missouri			

DATE REC'D BY LOCAL REG. 3-23-55		REGISTRAR'S SIGNATURE neva minshall		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS FLORAL HILLS MEMORIAL CHAPELS, INC. K.C.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..

Student.....
Signature of Student Embalmer

Signed *Clay C. McCord*.....

Licensed Embalmer No. *485*.....

P. O. Address *T. C. 7*.....

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.

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