

FILED MAR 27 1957

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATHSTATE FILE NO. 10233  
REGISTRAR'S NO. 2093

Registration District No. 318 Primary Registration District No. 1003

1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY						
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN St. Louis		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>				
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION O/ 6152 Pershing Ave			Length of stay in 1b 22 1/2 Yrs		d. STREET ADDRESS 6152 Pershing Ave		(If outside, give location) Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Dr. Jain Donn Ferguson				4. DATE OF DEATH Month Day Year March 1, 1957						
5. SEX Male <input checked="" type="checkbox"/>		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 21, 1925		9. AGE (In years last birthday) 31 IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Associate Prof. Physiology - St. Louis Univ				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) Glasgow, Scotland		12. CITIZEN OF WHAT COUNTRY? Great Britain		
13. FATHER'S NAME Morris Ferguson				14. MOTHER'S MAIDEN NAME Margaret Logan						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) No		16. SOCIAL SECURITY NO. None		17. INFORMANT (Wife) Mrs E. Muriel J. Ferguson		Address 6152 Pershing Ave				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Melanocarcinomatosis Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								INTERVAL BETWEEN ONSET AND DEATH 9 yrs		
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						19. WAS AUTOPSY PERFORMED? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
20c. TIME OF INJURY Hour Month, Day, Year a. m. p. m.			190X							
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION		COUNTY		STATE		
21. I attended the deceased from 1953 to 3-1-57 and last saw him alive on 2/26/57 Death occurred at 2:30 pm m on the date stated above; and to the best of my knowledge, from the causes stated.										
22a. SIGNATURE (Degree or title) Paul D. Hagemann MD				22b. ADDRESS 3720 Washington				22c. DATE SIGNED 3-2-57		
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		23b. DATE 3/2/57		23c. NAME OF CEMETERY OR CREMATORY Oak Grove Crematory		23d. LOCATION (City, town, or county) (State) St. Louis Co, Missouri				
24. FUNERAL DIRECTOR Alexander & Sons 6175 Delmar Blvd				25. DATE RECD. BY LOCAL REG. MAR 2 57		26. REGISTRAR'S SIGNATURE Charles Smith MD				

(Licensed Embalmer's Statement on Reverse Side)

Health,  
& Welfare  
Public  
Service5. 300  
1-56

All symptoms will be listed. All diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

securing the medical certificate in the same manner as a death certificate.

Dr. Hagemann  
St. Lukes

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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 *Joseph M. O'Connell*

Licensed Embalmer No. *246*

P. O. Address *6175 D.A.*

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.