

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

FILED AUG 15 1957

23423

STATE FILE NUMBER

Registration District No. 10 Primary Registration District No. 3002 Registrar's No. 190

1. PLACE OF DEATH				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)			
a. COUNTY <u>Audrain</u>		b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Mexico</u>		a. STATE <u>Missouri</u>		b. COUNTY <u>Callaway</u>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>1002 W. Harwood</u>		Length of stay in lb <u>4 Mo.</u>		c. CITY OR TOWN <u>Mokane</u>		Inside Limits <input checked="" type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print)				4. DATE OF DEATH			
First <u>Amelia</u>		Middle <u>Ann</u>		Last <u>Ferguson</u>		Month <u>Aug</u> Day <u>4</u> Year <u>57</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 10-1894</u>	9. AGE (In years last birthday) <u>83</u>	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>		11. BIRTHPLACE (City and state or country) <u>Mokane Mo</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>	
13. FATHER'S NAME <u>Gibson Smith</u>				14. MOTHER'S MAIDEN NAME <u>Frances DeRieux</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>---</u>		17. INFORMANT <u>OW Smith</u> Address <u>New Bloomfield</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]						INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Chronic Myocarditis</u>						<u>1 year</u>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Left Hemiplegia</u>						<u>3 years</u>	
DUE TO (c) <u>Hypertension</u>						<u>5 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Generalized arteriosclerosis - 7 years</u>						<u>443x</u>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						<u>2</u>	
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input checked="" type="checkbox"/> HOMICIDE <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>none</u>					
20c. TIME OF INJURY: Hour <u>---</u> Month <u>---</u> Day <u>---</u> Year <u>---</u> a. m. <u>---</u> p. m. <u>---</u>		20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>					
20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) <u>none</u>		20f. CITY, TOWN, OR LOCATION <u>---</u>		COUNTY <u>---</u>		STATE <u>---</u>	
21. I attended the deceased from <u>10/10/51</u> to <u>7/10/57</u> and last saw her alive on <u>7/10/57</u> . Death occurred at <u>3:50 P. m.</u> on the date stated above; and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) <u>Thos. L. Sawyer, M.D.</u>				22b. ADDRESS <u>Mexico, Mo.</u>		22c. DATE SIGNED <u>8/4/57</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE <u>Aug 6-57</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Mokane Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Mokane Mo</u>	
24. FUNERAL DIRECTOR <u>Le Roy Cloyd</u> ADDRESS <u>New Bloomfield</u>		25. DATE RECD. BY LOCAL REG. <u>Aug. 4-1957</u>		26. REGISTRAR'S SIGNATURE <u>Blanche Feely</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 .....  
Signature of Student Embalmer

Signed *Leroy Claypool* .....  
Licensed Embalmer No. 44

P. O. Address *New Bloom*

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.