

JURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-026622

FILED VS AUG 5 1959

STATE FILE NUMBER

Registration District No. _____ Primary Registration District No. _____ Registrar's **2-6966**

INDEXED

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
b. CITY (If outside corporate limits, give TOWNSHIP only) St. Louis		c. CITY OR TOWN St. Louis	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Homer Phillip Hosp		d. STREET ADDRESS (If outside, give location) 5211 CATES	

3. NAME OF DECEASED (Type or print) First ESTELL Middle _____ Last FERGUSON			4. DATE OF DEATH Month July Day 24 Year 1959		
5. SEX female	6. COLOR OR RACE Negro	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH Oct 12, 1916	9. AGE (last birthday) 42	IF UNDER 1 YEAR Months _____ Days _____

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife	10b. KIND OF BUSINESS OR INDUSTRY housewife	11. BIRTHPLACE (City and state or country) Melena Arkansas	12. CITIZEN OF WHAT COUNTRY U.S.
13a. FATHER'S NAME Jas. M. Davis	13b. MOTHER'S MAIDEN NAME Lillie Mary	14. NAME OF HUSBAND OR WIFE Forrest Ferguson	

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no	16. SOCIAL SECURITY NO. 492-24-7065	17. INFORMANT Address FORREST FERGUSON 5211 Cates
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of Uterus (cervix)		INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b)	
	DUE TO (c)	171X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)	PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
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19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	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.)
20c. TIME OF INJURY Hour _____ a.m. _____ p.m. Month, Day, Year _____	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 _____ and last saw her/him alive on _____
Death occurred at _____ on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <i>[Signature]</i>	22b. ADDRESS 1300 Clark	22c. DATE SIGNED 7/27/59
23. BURIAL, CREMATION, REMOVAL (Specify) removal	23b. DATE 29 July 1959	23c. NAME OF CEMETERY OR CREMATORY Greenwood Cemetery
24. FUNERAL DIRECTOR Reliable Funeral Sys. 1389 N. Union		23d. LOCATION (City, town, or county) (State) St. Louis Co. Mo.

25. DATE RECD. BY LOCAL REG. JUL 27 '59	26. REGISTRAR'S SIGNATURE <i>[Signature]</i>
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DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed

John R. Curran

Licensed Embalmer No. 4476

P. O. Address 2405 M

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.