

JRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

60-033587

FILED VS SEP 13 1960

Registration District No. 360 Primary Registration District No. 6225 Registrar's No. 184

STATE FILE NUMBER

INDEXED

1. PLACE OF DEATH				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)			
a. COUNTY <u>Vernon</u>		b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Washington Township</u>		c. CITY OR TOWN <u>Nevada</u>		d. STREET ADDRESS (If outside, give location) <u>523 E. Lee Str.</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Washington Township</u>		Length of stay in 1b <u>1 mo 1 week</u>		c. CITY OR TOWN <u>Nevada</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>State Hospital No. 3</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>523 E. Lee Str.</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)				4. DATE OF DEATH			
First <u>Roy</u>		Middle		Last <u>FERGUSON</u>		Month <u>9</u> Day <u>4</u> Year <u>1960</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>6-22-1893</u>	9. AGE (last birthday) <u>67</u>	IF UNDER 1 YEAR	IF UNDER 24 HR	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Road construction</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) <u>Mount Rose, Mo</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13a. FATHER'S NAME <u>William Thomas Ferguson</u>		13b. MOTHER'S MAIDEN NAME <u>Sarah E. Gurby</u>		14. NAME OF HUSBAND OR WIFE <u>Maudie Ferguson</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>702-18-4981</u>		17. INFORMANT <u>Hospital record</u> Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:						INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (a) <u>arteriosclerotic heart disease</u>						<u>years</u>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>arteriosclerosis</u>						<u>years</u>	
DUE TO (c)							
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		
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" 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	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 <u>7-27-1960</u> to <u>9-4-1960</u> and last saw her/him alive on <u>9-4-1960</u> Death occurred at <u>7:35</u> p.m. on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) <u>Leslie H. Wright M.D.</u>			22b. ADDRESS <u>State Hospital No 3 - Nevada</u>			22c. DATE SIGNED <u>mo 9/4/1960</u> (State)	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE <u>9-7-60</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Newton</u>		23d. LOCATION (City, town, or county) <u>Vernon Co., Mo.</u>			
24. FUNERAL DIRECTOR <u>Richard H. Shover, Nevada, Mo.</u> ADDRESS		25. DATE RECD. BY LOCAL REG. <u>9-6-1960</u>		26. REGISTRAR'S SIGNATURE <u>Uma E. Perry</u>			

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

SEP 19 1960

0961 9 100

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 Lloyd C. McCarty

Licensed Embalmer No. 4853

P. O. Address Merida, Mo.

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.