

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-62-016767

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. **4090**

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

FILED APR 25 1962

VS 300
Rev. 4/59

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DATE AMENDED
2/5/59
AMENDMENTS ON THIS RECORD ARE AS FOLLOWS
INSTEAD OF
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SHOULD READ

DOCUMENT
MEDICAL CERTIFICATION
BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis, Mo.		Length of stay in 1b	c. CITY OR TOWN St. Louis,
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Lutheran Hosp.		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 3970 Randall.
3. NAME OF DECEASED (Type or print) First Marie. Middle Ferguson. Last		4. DATE OF DEATH Month April Day 17 Year 1962	
5. SEX Female.	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 3-27-07
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (last birthday) 55
11. BIRTHPLACE (City and state or country) Ohio,		12. CITIZEN OF WHAT COUNTRY U.S.A.	
13a. FATHER'S NAME Charles T. Snyder.		13b. MOTHER'S MAIDEN NAME Letha White.	14. NAME OF HUSBAND OR WIFE William O. Ferguson.
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	17. INFORMANT William O. Ferguson. 3970 Randall.
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) RUPTURED AORTA			INTERVAL BETWEEN ONSET AND DEATH 6 HOURS
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) ATHEROMATOUS PLAQUES OF AORTA			
DUE TO (c) HYPER CHOLESTREMIA (POSSIBLE)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 451x			PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown
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 --- 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 ---	
21. I attended the deceased from 10 APRIL 1962 to 17 APRIL 1962 and last saw her/him alive on 17 APRIL 1962		21. Death occurred at 9:20 A-m on the date stated above, and to the best of my knowledge, from the causes stated.	
22a. SIGNATURE (Degree or title) E. N. Schmidt, M.D.		22b. ADDRESS 6500 CHIPPEWA, St. Louis 9, Mo.	
22c. DATE SIGNED 4/17/62		23. LOCATION (City, town, or county) (State) Portsmouth, Ohio	
23a. BURIAL, CREMATION, REMOVAL (Specify) removal-train		23b. DATE 4-20-62	
23c. NAME OF CEMETERY OR CREMATORY Greenlawn Cem.		23d. LOCATION (City, town, or county) (State) Portsmouth, Ohio	
24. FUNERAL DIRECTOR ADDRESS Southern Funeral Home 6322 S. Grand, St. Louis, Mo.		25. DATE RECD. BY LOCAL REG. APR 19 1962	
26. REGISTRAR'S SIGNATURE Loard Smith, M.D.			

USE BLACK INK OR TYPEWRITER RIBBON

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 David Van Fossen.

Licensed Embalmer No. 4292

P. O. Address St Louis 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.