

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

26950

PLACE OF DEATH
County Pettis
Township Sedalia
or
Village
or
City Sedalia, Mo. (NO. 1808, South Harrison St.)

Registration District No. 668

File No.

Primary Registration District No. 3032Registered No. 203

(If death occurred in a hospital or institution, give its NAME instead of street and number)

FULL NAME Mrs. Bettie Ferguson

PERSONAL AND STATISTICAL PARTICULARS

SEX Female COLOR OR RACE White SINGLE MARRIED WIDOWED OR DIVORCED Married
(Write the word)
DATE OF BIRTH Feb. 7 - 1849
(Month) (Day) (Year)
AGE 65 yrs. 6 mos. 15 ds. IF LESS than 1 day, ____ hrs. or ____ min.?

OCCUPATION

(a) Trade, profession, or particular kind of work House Wife

(b) General nature of industry, business, or establishment in which employed (or employer)

BIRTHPLACE

(City or town, State or foreign country) KentuckyNAME OF FATHER James Redd

BIRTHPLACE OF FATHER

(City or town, State or foreign country) KentuckyMAIDEN NAME OF MOTHER Martha Stark

BIRTHPLACE OF MOTHER

(City or town, State or foreign country) Kentucky

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) M. H. Ferguson(ADDRESS) 1808 S. Harrison St.Filed 8/24 1914REGISTRAR H. B. Long

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Aug 22 1914
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Aug 11 1914 to Aug 22 1914, that I last saw her alive on Aug 22 1914 and that death occurred, on the date stated above, at 10 26 p.m.
The CAUSE OF DEATH* was as follows:

Wrenie prison
131
13713 (Duration) ____ yrs. ____ mos. 7 ds.

Contributory Bright disease
(SECONDARY) (Duration) ____ yrs. ____ mos. ____ ds.
(Signed) Dr. J. B. Long M. D.Aug 24 1914 (Address) Sedalia, Mo.

(State the Disease Causing Death, or, in deaths from Violent Causes, state Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.)

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ____ yrs. ____ mos. ____ ds. In the State ____ yrs. ____ mos. ____ ds.

Where was disease contracted If not at place of death?

Former or usual residence

PLACE OF BURIAL OR REMOVAL Smithton CemeteryDATE OF BURIAL Aug. 24 1914UNDERTAKER Purbaugh & Allen Fun. Co.ADDRESS Sedalia, Mo.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

MISSOURI STATE BOARD OF HEALTH
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CERTIFICATE OF DEATH

PLACE OF DEATH

County _____
Township _____ or Village _____
City _____
Registration District No. _____
Primary Registration District No. _____
St. _____ Ward _____
File No. _____
Registered No. _____
[If death occurred in a hospital or institution, give its NAME instead of street and number]

FULL NAME

PERSONAL AND STATISTICAL PARTICULARS

SEX	COLOR OR RACE	SINGLE MARRIED WIDOWED OR DIVORCED (Write the word)
DATE OF BIRTH	(Month) _____ (Day) _____ (Year) _____	
AGE	_____ yrs. _____ mos. _____ ds.	IF LESS than 1 day, _____ hrs. or _____ min. ?
OCCUPATION	(a) Trade, profession, or particular kind of work _____ (b) General nature of industry, business, or establishment in which employed (or employer) _____	
BIRTHPLACE	(City or town, State or foreign country) _____	
NAME OF FATHER	_____	
BIRTHPLACE OF FATHER	(City or town, State or foreign country) _____	
MAIDEN NAME OF MOTHER	_____	
BIRTHPLACE OF MOTHER	(City or town, State or foreign country) _____	

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) _____

(ADDRESS) _____

Filed _____

191 _____

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH

_____, 191 _____ (Month) _____ (Day) _____ (Year)

I HEREBY CERTIFY, that I attended deceased from _____, 191 _____, to _____, 191 _____

that I last saw him alive on _____, 191 _____

and that death occurred, on the date stated above, at _____ m.

The CAUSE OF DEATH* was as follows:

(Duration) _____ yrs. _____ mos. _____ ds.

Contributory

(SECONDARY)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed)

_____, 191 _____ (Address)

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury, and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RESIDENT RESIDENTS)

At place of death, _____ yrs. _____ mos. _____ ds. State _____ yrs. _____ mos. _____ ds.

Where was disease contracted if not at place of death?

Former or usual residence _____

PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

UNDERTAKER

ADDRESS

191 _____