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
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

PLACE OF DEATH

County: Clark

Township: Prairie

or Village: Alexandria

or City: _____ (NO. _____, _____ St.; _____ Ward)

Registration District No. 189 — File No. 32256

Primary Registration District No. 5263 — Registered No. _____

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

FULL NAME Thos Howard Ferguson

PERSONAL AND STATISTICAL PARTICULARS

SEX: Female

COLOR OR RACE: White

~~SINGLE~~ MARRIED ~~WIDOWED~~ ~~OR DIVORCED~~ (Write the word)

DATE OF BIRTH: Sept 2, 1890 (Month) (Day) (Year)

AGE: 28 yrs. _____ mos. 16 ds. — If LESS than 1 day, ____ hrs. or ____ min.?

OCCUPATION
(a) Trade, profession, or particular kind of work: Home wife
(b) General nature of industry, business, or establishment in which employed (or employer): _____

BIRTHPLACE (City or town, State or foreign country): Barton Mo

PARENTS

NAME OF FATHER: Henry Degner

BIRTHPLACE OF FATHER (City or town, State or foreign country): La Grange Mo

MAIDEN NAME OF MOTHER: Mary Drillbliss

BIRTHPLACE OF MOTHER (City or town, State or foreign country): Barton Mo

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mr Ferguson

(ADDRESS) Alexandria Mo

Filed Oct 14, 1918. F A S Rebo
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH: Oct 13, 1918 (Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Oct 9, 1918, to Oct 13, 1918, that I last saw her alive on Oct 13, 1918, and that death occurred, on the date stated above, at 8 a m.

The CAUSE OF DEATH* was as follows:

Acute Pneumonia

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

Contributory (SECONDARY) _____

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

(Signed) Dr F A S Rebo M. D.

Oct 14, 1918 (Address) Alexandria Mo

*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 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: Barton Mo

DATE OF BURIAL: Oct 16, 1918

UNDERTAKER: H F Kinder

ADDRESS: Wayland Mo

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

PLACE OF DEATH

County.....

Township ..... Registration District No..... File No.....

or

Village..... Primary Registration District No..... Registered No.....

or

City .....(NO....., ...St.....Ward)

[If death occurred hospital or institu give its NAME in of street and numbe

FULL NAME.....

PERSONAL AND STATISTICAL PARTICULARS

SEX	COLOR OR RACE	SINGLE MARRIED WIDOWED OR DIVORCED (*Write* the word)

DATE OF BIRTH

....., 1.....
(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)

PARENTS

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) (Y

I HEREBY CERTIFY, that I attended deceased f

....., 191...., to....., 191

that I last saw h.....alive on....., 191

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

The CAUSE OF DEATH* was as follows:

.....

.....

.....

.....(Duration).....yrs.....mos.....

Contributory.....
(SECONDARY)

.....(Duration).....yrs.....mos.....

(Signed)..... M

....., 191..... (Address).....

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

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

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

Where was disease contracted if not at place of death? .....

Former or usual residence.....

PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
	....., 19
UNDERTAKER	ADDRESS

...WITH UNFADING INK...IS A PERMANENT RECORD

...Sunshine state