Reagan Hunt

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

1 PLACE OF DEATH

County Macon

Township Narrows
or
Village
or
City (NO. St.; Ward)

Registration District No. 535 File No. 20124 5

Primary Registration District No. 5719 Registered No. 5

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

2 FULL NAME Jas M. Ferguson

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male

4 COLOR OR RACE White

5 SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) Married

6 DATE OF BIRTH Sep 14 (Month) (Day) 1848 (Year)

7 AGE 70 yrs. 8 mos. 21 ds.

If LESS than 1 day, ...hrs. or ....min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry business, or establishment in which employed (or employer)

9 BIRTHPLACE (City or town, State or foreign country) Huntsville Mo

PARENTS

10 NAME OF FATHER Jas. M Ferguson

11 BIRTHPLACE OF FATHER (City or town, State or foreign country) Tenn.

12 MAIDEN NAME OF MOTHER. Mary Dorsey

13 BIRTHPLACE OF MOTHER (City or town, State or foreign country) Randolph Co Mo

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Hunter Ferguson

(Address) Macon Mo RR

15 Filed June 10, 1919 J A Ryan Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH 6/5 (Month) (Day) 1919 (Year)

17 I HEREBY CERTIFY, that I attended deceased from Jan, 1918, to Jany, 1919, that I last saw h. alive on Decemb, 1918, and that death occurred, on the date stated above, at 6 9 m.

The CAUSE OF DEATH* was as follows:

Gastric Cancer

(Duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) J R Hunt

(Duration) yrs. mos. ds.

(Signed) J R Hunt M. D.

June 5, 1919 (Address) Macon Mo

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

18 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

19 PLACE OF BURIAL OR REMOVAL Mt Salem Cemetery

DATE OF BURIAL June 6, 1919

20 UNDERTAKER Albert Skinner

ADDRESS Macon 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.

LOCAL REGISTRAR'S RECORD DO NOT TEAR LEAF OUT

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

1 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 in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME .....

PERSONAL AND STATISTICAL PARTICULARS

3 SEX | 4 COLOR OR RACE | 5 SINGLE MARRIED WIDOWED OR DIVORCED (*Write* the word)

6 DATE OF BIRTH ..... (Month) ..... (Day), 1..... (Year)

7 AGE ..... yrs. ..... mos. ..... ds. | If LESS than 1 day, ... hrs. or ..... min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work .....
(b) General nature of industry business, or establishment in which employed (or employer) .....

9 BIRTHPLACE (City or town, State or foreign country)

PARENTS
10 NAME OF FATHER
11 BIRTHPLACE OF FATHER (City or town, State or foreign country)
12 MAIDEN NAME OF MOTHER
13 BIRTHPLACE OF MOTHER (City or town, State or foreign country)

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) .....

(Address) .....

15

Filed ....., 191....., ...
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH June 5 (Month) ..... (Day), 1919 (Year)

17 I HEREBY CERTIFY, that I attended deceased from Jan ....., 1918, to June ....., 1919, that I last saw him alive on Dec ....., 1918, and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

Gastric Cancer

..... (Duration) 2 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

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

(Signed) G. R. Hunt M. D.

June 6, 1919 (Address) Marion Mo.

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

18 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 .....

19 PLACE OF BURIAL OR REMOVAL | DATE OF BURIAL ....., 191....

20 UNDERTAKER | ADDRESS

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.