

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

Do not use this space.

22671

**1. PLACE OF DEATH**

County..... Registration District No. **791**  
 Township..... Primary Registration District No. **1003**  
 City..... (No. **8217 Reilly a**) St. .... Ward)

File No. ....  
 Registered No. **6323**

**2. FULL NAME** *Nora Ferguson*

(a) Residence. No. *8217 Reilly a* St. *1* Ward. ....  
 (Usual place of abode) (If nonresident give city or town and State)  
 Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

**PERSONAL AND STATISTICAL PARTICULARS**

**3. SEX** *Female* | **4. COLOR OR RACE** *White* | **5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)** *Widow*

**5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF** *Matthew Ferguson*

**6. DATE OF BIRTH (MONTH, DAY AND YEAR)** *Oct. 11-1863*

**7. AGE**

YEARS	MONTHS	DAYS	IF LESS than 1 day, hrs. or min.
<i>63</i>	<i>8</i>	<i>28</i>	

**8. OCCUPATION OF DECEASED**

(a) Trade, profession, or particular kind of work *at home* <sup>93</sup>

(b) General nature of industry, business, or establishment in which employed (or employer) <sup>95</sup>

(c) Name of employer <sup>112</sup>

**9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)** *Ireland*

**10. NAME OF FATHER** *Martin Ryan*

**11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY)** *Ireland*

**12. MAIDEN NAME OF MOTHER** *May Leahy*

**13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY)** *Ireland*

**14. INFORMANT** *Matt Ferguson*  
 (Address) *8217 Reilly a*

**15. FILED** *11 1927* *M. A. Starkoff*  
 REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

**16. DATE OF DEATH (MONTH, DAY AND YEAR)** *July 9- 1927*

**17. I HEREBY CERTIFY** That I attended deceased from *Jan 1907* to *1927* that I last saw him alive on *7/8* 19*27* and that death occurred, on the date stated above, at *112* m.

**THE CAUSE OF DEATH\* WAS AS FOLLOWS**

*Detention of Heart*  
*Chronic Myocarditis*  
 (duration) yrs. mos. ds.  
**CONTRIBUTORY (SECONDARY)** *Bronchial Asthma*  
*Non Tubercular* (duration) yrs. mos. ds.

**18. WHERE WAS DISEASE CONTRACTED** *90 B*  
 (IF NOT AT PLACE OF DEATH)  
 DID AN OPERATION PRECEDE DEATH? *No* DATE OF .....  
 WAS THERE AN AUTOPSY? *No*  
 WHAT TEST CONFIRMED DIAGNOSIS?  
 (Signed) *A. H. Peters*, M. D.

*July 10, 1927* (Address) *601 Mission Bldg*  
 \*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

**19. PLACE OF BURIAL, CREMATION, OR REMOVAL** *Mount Olive* **DATE OF BURIAL** *7-12-1927*

**20. UNDERTAKER** *Southern* **ADDRESS** *7315 S. Broadway*

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.

*P. lery*

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