JUN 25 1929

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

Do not use this space.

17837

1. PLACE OF DEATH
County Greene — Registration District No. 318 — File No.
Township — Primary Registration District No. 2091 — Registered No. 405
City Springfield (No. St. John Hospital St. Ward)

2. FULL NAME John R. Ferguson
(a) Residence. No. Springfield Mo 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: M
4. COLOR OR RACE: Wh
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word): Wid

5A. ~~IF MARRIED, WIDOWED, OR DIVORCED~~ HUSBAND OF (OR) WIFE OF Virginia Ferguson

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Feb 10-1842

7. AGE: Years 87 — Months 3 — Days 11 — If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Retd
(b) General nature of industry, business, or establishment in which employed (or employer): Merchant
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): Pike Co. Mo.

PARENTS
10. NAME OF FATHER: John S Ferguson
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY): Va
12. MAIDEN NAME OF MOTHER: Elizabeth Allison
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY): Ky

14. INFORMANT: E R Ferguson
(Address) Springfield Mo

15. FILED 5-22 1929 [signature] REGISTRAR

MEDICAL CERTIFICATE OF DEATH

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16. DATE OF DEATH (MONTH, DAY AND YEAR) 5-21 1929

17. I HEREBY CERTIFY, That I attended deceased from Apr 17, 1929, to May 21, 1929 that I last saw him alive on May 20 1929, and that death occurred, on the date stated above, at 8 A.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Pneumonia - Lobar
108
137
(duration) yrs. mos. 3 ds.

CONTRIBUTORY (SECONDARY) Prostatic Hypertrophy
(duration) 3 yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED?
IF NOT AT PLACE OF DEATH?
DID AN OPERATION PRECEDE DEATH? no DATE OF
WAS THERE AN AUTOPSY? no
WHAT TEST CONFIRMED DIAGNOSIS? Clinical
(Signed) [signature], M. D
May 22, 1929 (Address) 413 Holland 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: Hazelwood — DATE OF BURIAL: 5-23 1929

20. UNDERTAKER: Alma Lohmeyer — ADDRESS: 504 St Louis

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.

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J. B. Camp,