

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

Do not use this space.

12487

1. PLACE OF DEATH

County Jackson Registration District No. 398
 Township Independence Primary Registration District No. 2019
 City Independence (No. _____) St. _____ Ward _____

File No. _____
 Registered No. 119

2. FULL NAME Alice Amanda Ferguson

(a) Residence. No. 401 N Union St. _____ 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) widowed

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF John R. Ferguson

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Nov 6 - 1860

7. AGE	YEARS	MONTHS	DAYS	IT LESS than 1 day, _____ hrs. or _____ min.
<u>69</u>	<u>5</u>	<u>6</u>		

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

9. BIRTHPLACE (CITY OR TOWN) Independence
 (STATE OR COUNTRY) Mo.

10. NAME OF FATHER John Smith

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

12. MAIDEN NAME OF MOTHER Amanda Davis

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) Jackson Co. Mo.

14. INFORMANT Nellie Ferguson
 (Address) 401 N Union

15. FILED 4-16, 1930 F L Cook
 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) April 12 1930

17. I HEREBY CERTIFY, That I attended deceased from 11 AM 22, 1929, to April 12 1930 that I last saw h. w. alive on April 12 1930, and that death occurred, on the date stated above, at 11 P. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Coma of stomach

46 B
 (duration) _____ yrs. _____ mos. _____ ds.

CONTRIBUTORY (SECONDARY) 4 of 10
 (duration) _____ yrs. _____ mos. _____ ds.

18. WHERE WAS DISEASE CONTRACTED
 IF NOT AT PLACE OF DEATH. _____

19. DID AN OPERATION PRECEDE DEATH? no DATE OF _____

20. WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS Clinical
 (Signed) N. A. Hancock M. D.

4-15-1930 (Address) Buckner Mo.

*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 Salem Cem. DATE OF BURIAL April 14 1930

20. UNDERTAKER Ott + Mitchell ADDRESS Independence Mo.

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

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.

26 1930

