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

Do not use this space.

18465

1. PLACE OF DEATH
County: Nodaway
Township: Mt Grove
City: Mt Grove (No. ..... St. ..... Ward)

Registration District No. 408
Primary Registration District No. 4549

File No. .....
Registered No. 17

2. FULL NAME: Edward Ferguson

(a) Residence. No. ..... St., ... Ward. .....
(Usual place of abode) (If nonresident, give city or town and State)

Length of residence in city or town where death occurred 18 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)
Male	White	Divorced

5A. ~~If Married, Widowed, or~~ Divorced
HUSBAND OF ~~(OR) WIFE OF~~: Mary Ferguson

6. DATE OF DATH (MONTH, DAY AND YEAR): unknown

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
about	72	—	—	

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

9. BIRTHPLACE (CITY OR TOWN): Bryne Co
(STATE OR COUNTRY): Boone Co Iowa

PARENTS
10. NAME OF FATHER: Samuel Ferguson
11. BIRTHPLACE OF FATHER (CITY OR TOWN): unknown
(STATE OR COUNTRY): .....
12. MAIDEN NAME OF MOTHER: unknown
13. BIRTHPLACE OF MOTHER (CITY OR TOWN): unknown
(STATE OR COUNTRY): .....

14. INFORMANT: Leona Leaf
(Address): 1710 Davenport St & Omaha Neb.

15. FILED 5/30, 1930 [signature] REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR): 5-27- 1930

17. I HEREBY CERTIFY, That I attended deceased from 5/24, 1930, to 5/27, 1930, that I last saw him alive on 5/24, 1930, and that death occurred, on the date stated above, at 6 A.M. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Angina Pectoris
48 A
..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (SECONDARY) .....
..... (duration) ..... 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) R. A. Ryan, M. D.
5/30, 1930 (Address) Mt Grove

*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: Stubbs Cemetery
DATE OF BURIAL: 5-27- 1930

20. UNDERTAKER: none
ADDRESS: —

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.