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.

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

Do not use this space.

31017

791

1. PLACE OF DEATH

County ..... Registration District No. ..... File No. .....

Township ..... Primary Registration District No. ..... Registered No. 8743

City St. Louis Mo. (No. Cetr. Hospital St. ..... Ward)

2. FULL NAME Mary E. Ferguson

(a) Residence, No. 3929 Botanical St., 17 Ward. (If nonresident, give city or town and State)
(Usual place of abode)

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): married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF: Samuel D. Ferguson

6. DATE OF BIRTH (MONTH, DAY, AND YEAR): Dec 2 1870

7. AGE: YEARS 61 MONTHS 9 DAYS 27 If LESS than 1 day, ... hrs. or ..... min.

OCCUPATION
8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc.: House Keeper
9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.: 235
10. Date deceased last worked at this occupation (month and year): 1864
11. Total time (years) spent in this occupation: 1868

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): Loreland 15

FATHER
13. NAME: Unknown
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): Unknown 318

MOTHER
15. MAIDEN NAME: Unknown
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): Unknown

17. INFORMANT (ADDRESS): Mr Samuel D. Ferguson 3929 Botanical

18. BURIAL, CREMATION, OR REMOVAL
PLACE Lakewood Park DATE Oct 1 1932

19. UNDERTAKER (ADDRESS): E. J. Schnur 3125 Lafayette Av.

20. FILED SEP 30 1932 19 Max C. Stanley Registrar.

2 MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR): Sept. 29, 1932

22. No Physician in attendance I HEREBY CERTIFY, That I attended deceased from ....., 19....., to ....., 19.....

I last saw h..... alive on ....., 19..... Death is said to have occurred on the date stated above, at 9 05 a m.

The principal cause of death and related causes of importance were as follows:

	Date of onset
Ruptured Right Kidney, Fractured Right Tibia and Fibula, received in fall to floor at residence	
Other contributory causes of importance:	
1860 Accident (1)	5

Name of operation ..... Date of .....

What test confirmed diagnosis? ..... Was there an autopsy? Yes

23. If death was due to external causes (violence), fill in also the following:

Accident, suicide, or homicide? Accident Date of injury 9/18, 1932

Where did injury occur? St Louis Mo. (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place. In Home

Manner of injury Fall to floor

Nature of injury Ruptured Right Kidney

24. Was disease or injury in any way related to occupation of deceased? .....

If so, specify .....

(Signed) J. W. Kenner, M.D.

(Address) Def. Corner

9/30/32