

REC'D APR 15 1938

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

Do not use this space.

10042

1. PLACE OF DEATH  
 County Daviess Registration District No. 34  
 Township Liberty Primary Registration District No. 5050  
 City Clinton (No. ....) St. .... Ward .....

2. FULL NAME Rubin Alexander Ferguson  
 (a) Residence, No. .... St. .... Ward .....

Length of residence in city or town where death occurred 80 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 White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) married

5A. IF MARRIED, WIDOWED, OR DIVORCED (OR) WIFE OF Cligarr Ferguson

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Jan. 18-1859

7. AGE YEARS 79 MONTHS 1 DAYS 10 If LESS than 1 day, .... hrs. or .... min.

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Farmer

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. ....

10. Date deceased last worked at this occupation (month and year) Sept. 19 37 11. Total time (years) spent in this occupation 34 1/2

12. BIRTHPLACE (CITY OR TOWN) D. V. (STATE OR COUNTRY) Mo

13. NAME George W. Ferguson

14. BIRTHPLACE (CITY OR TOWN) D. V. (STATE OR COUNTRY) Mo

15. MAIDEN NAME Louisa Hammond

16. BIRTHPLACE (CITY OR TOWN) D. V. (STATE OR COUNTRY) Mo

17. INFORMANT Anna Ferguson (ADDRESS) Clinton, Mo

18. BURIAL, CREMATION, OR REMOVAL PLACE Missouri DATE 3-1-1938

19. UNDERTAKER Barth Blankenship (ADDRESS) Clinton, Mo

20. FILED 3-1-1938 Ms. H. P. Searcy Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Feb. 27-1938

22. I HEREBY CERTIFY, That I attended deceased from Oct 20, 1937, to Feb 5, 1938. I last saw him alive on Feb 5, 1938. Death is said to have occurred on the date stated above, at 6-A. m.

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

Chronic Myocarditis ?

Other contributory causes of importance: Chronic nephritis Hypertension

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

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

23. If death was due to external causes (violence), fill in also the following: Accident, suicide, or homicide? ..... Date of injury ..... 19..... Where did injury occur? ..... (Specify city or town, county, and State) Specify whether injury occurred in industry, in home, or in public place. ....

Manner of injury .....

Nature of injury .....

24. Was disease or injury in any way related to occupation of deceased? ..... If so, specify Chronic Myocarditis (Signed) W. M. ... M. D. (Address) Clinton, Mo



FILL IN ANSWERS TO ALL SPACES  
CHECKED IN RED PENCIL.

MISSOURI STATE BOARD OF HEALTH  
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1. PLACE OF DEATH

(a) County Barry Registration District No. 34  
(b) Township Liberty Primary Registration District No. 5000 Registered No. ....  
(c) City ..... (d) Street No. .... St. ....  
(If death occurred in Hospital or Institution, write its name instead of street and number)  
(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U.S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME

Ruben Alexander Ferguson  
(a) Residence, No. .... St.  (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX m 4. COLOR OR RACE w 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED m (write the word)

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

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

7. AGE YEARS MONTHS DAYS If LESS than 1 day, ..... hrs. or ..... min.  
69 1 10

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

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

FATHER 13. NAME

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

MOTHER 15. MAIDEN NAME

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

17. INFORMANT (ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL

PLACE ..... DATE ..... 19

19. FUNERAL DIRECTOR (ADDRESS)

20. FILED July 3 1938 Mrs. W. P. Sease Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Feb 28 1938

22. I HEREBY CERTIFY, That I attended deceased from

I last saw h. .... alive on ..... 19..... Death is said

to have occurred on the date stated above, at ..... m.

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

Date of onset

Other contributory causes of importance:

Name of operation ..... Date of

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

23. If death was due to external causes (violence), fill in also the following: Accident, suicide, or homicide? ..... Date of injury ..... 19.....

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

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

Manner of injury .....

Nature of injury .....

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

If so, specify (Signed) E. E. McDonald, M. D.

(Address) Carroll mo

SUPPLEMENTARY

REMARKS: SMALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.

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