

REG. DIST. NO. 288

Primary Registration District No. 5404

State File No. \_\_\_\_\_

Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH:

(a) County Dunklin  
(b) City or town Black Oak Twp.  
(c) Name of hospital or institution: Home  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 2 (Specify whether years, months or days)

In this community \_\_\_\_\_ years, months or days

3. (a) PRINT FULL NAME W. M. Ferguson

3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced \_\_\_\_\_

6. (b) Name of husband or wife Lula Ferguson 6. (c) Age of husband or wife if alive 33 years

7. Birth date of deceased Oct. 15 1886  
(Month) (Day) (Year)

8. AGE: Years 54 Months 2 Days 13 If less than one day 3 hr. 30 min.

9. Birthplace Dunklin County (City, town, or county) (State or foreign country)

10. Usual occupation laborer

11. Industry or business \_\_\_\_\_

12. Name Kenny Ferguson

18. Birthplace \_\_\_\_\_ (City, town, or county) (State or foreign country)

14. Maiden name Sara Floyd

15. Birthplace \_\_\_\_\_ (City, town, or county) (State or foreign country)

16. (a) Informant's own signature Lula Ferguson  
(b) Address \_\_\_\_\_

17. (a) Burial (b) Date thereof 2/3-40  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Blainfield

18. (a) Signature of funeral director Carroll's Funeral Home  
(b) Address Campbell Mo 950

19. (a) 3-5-1940 (b) J. H. Anderson  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Dunklin  
(c) City or town Clarkston R 1  
(If outside city or town limits, write "RURAL")  
(d) Street No. 0 (If rural, give location)  
(e) If foreign born, how long in U. S. A. \_\_\_\_\_ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb day 2 year 1940 hour 9 minute 30 A. M.

21. I hereby certify that I attended the deceased from Jan 10 to Feb 2 1940 and that death occurred on the date and hour stated above.

Immediate cause of death Chronic Pneumonia Duration LOBFR

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_ (include pregnancy within 3 months of death)

Major findings: Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) \_\_\_\_\_  
(b) Date of occurrence \_\_\_\_\_  
(c) Where did injury occur? \_\_\_\_\_ (City or town) (County) (State)  
(d) Did injury occur in or about home, on farm, in industrial place, in public place? \_\_\_\_\_

While at work? \_\_\_\_\_ (Specify type of place) (e) Means of injury \_\_\_\_\_

23. Signature J. A. J. Presnell (M. D. or other) \_\_\_\_\_  
Address Permitt Mo Date signed \_\_\_\_\_

MARGIN RESERVED FOR BINDING

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PENCIL RECORD OF ALL CHANGES

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS' CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

109

RECEIVED  
District Health Office  
District File Number 340  
Date Filed 3/13

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

Christian M. Sanders....., Registered Apprentice No. 67

working under my personal supervision.

Signed E. W. Sanders.....

Licensed Embalmer No. 2289 Ms.

P. O. Address Campbell.....

**Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)**

**If this body is not embalmed, above space should be left blank.**

B  
40  
2559  
32

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 6507

Registration District No. 286

Primary Registration District No. 3404

Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH:

(a) County Franklin

(b) City or town Walscomb Twp  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: \_\_\_\_\_  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution \_\_\_\_\_  
(Specify whether \_\_\_\_\_)

In this community \_\_\_\_\_  
(years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State \_\_\_\_\_ (b) County \_\_\_\_\_

(c) City or town \_\_\_\_\_  
(If outside city or town limits write "RURAL")

(d) Street No. \_\_\_\_\_  
(If rural, give location)

(e) If foreign born, how long in U. S. A. \_\_\_\_\_ years.

3. (a) PRINT FULL NAME W. M. Ferguson

3. (b) If veteran, name war WW

3. (c) Social Security No. \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb day 2  
year 1940 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

4. Sex m

5. Color or race w

6. (a) Single, widowed, married, divorced w

6. (b) Name of husband or wife \_\_\_\_\_

6. (c) Age of husband, or wife, if alive \_\_\_\_\_ year

7. Birth date of deceased: (Month) \_\_\_\_\_ (Day) \_\_\_\_\_ (Year) \_\_\_\_\_

21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_;  
that I last saw h \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_,  
and that death occurred on the date and hour stated above.

Immediate cause of death Pneumonia Lobar

8. AGE: Years Months Days If less than one day

34 2 13 3 h 30 min.

Due to \_\_\_\_\_

Due to \_\_\_\_\_

9. Birthplace: \_\_\_\_\_  
(City, town, or county) \_\_\_\_\_ (State or foreign country)

Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

10. Usual occupation \_\_\_\_\_

Major findings: \_\_\_\_\_  
Of operations \_\_\_\_\_

11. Industry or business \_\_\_\_\_

Of autopsy \_\_\_\_\_

12. Name \_\_\_\_\_

13. Birthplace: \_\_\_\_\_  
(City, town, or county) \_\_\_\_\_ (State or foreign country)

14. Maiden name \_\_\_\_\_

15. Birthplace: \_\_\_\_\_  
(City, town, or county) \_\_\_\_\_ (State or foreign country)

16. (a) Informant \_\_\_\_\_

(b) Address \_\_\_\_\_

17. (a) \_\_\_\_\_ (b) Date thereof \_\_\_\_\_  
(Burial, cremation, or removal) \_\_\_\_\_ (Month) (Day) (Year)

(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_

(b) Address \_\_\_\_\_

19. (a) \_\_\_\_\_ (b) \_\_\_\_\_  
(Date received local registrar) \_\_\_\_\_ (Registrar's signature)

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) \_\_\_\_\_

(b) Date of occurrence \_\_\_\_\_

(c) Where did injury occur? \_\_\_\_\_  
(City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State) \_\_\_\_\_

(d) Did injury occur in or about home, on farm, in industrial place, in public place? \_\_\_\_\_

While at work? \_\_\_\_\_ (Specify type of place)  
(e) Means of injury \_\_\_\_\_

23. Signature U. A. V. Presnell  
Address Keenett

Duration \_\_\_\_\_

PHYSICIAN \_\_\_\_\_

Underline the cause to which death should be charged statistically.

SUPPLEMENTARY

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 65-07

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

Registration District No. 286

Primary Registration District No. 3404

Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH:

(a) County Dunklin  
(b) City or town Nalcoomb, Mo  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_  
(Specify whether  
In this community: \_\_\_\_\_  
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State \_\_\_\_\_ (b) County \_\_\_\_\_  
(c) City or town \_\_\_\_\_  
(If outside city or town limits write "RURAL")  
(d) Street No. \_\_\_\_\_  
(If rural, give location)  
(e) If foreign born, how long in U. S. A.? \_\_\_\_\_ years.

3. (a) PRINT FULL NAME

William M. Ferguson

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb day 2  
year \_\_\_\_\_ hour \_\_\_\_\_ minute \_\_\_\_\_ M.

3. (b) If veteran name war W

3. (c) Social Security No. \_\_\_\_\_

4. Sex M

5. Color or race W

6. (a) Single, widowed, married, divorced m

6. (b) Name of husband or wife \_\_\_\_\_

6. (c) Age of husband, or wife, if alive \_\_\_\_\_ years

21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_; that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_, and that death occurred on the date and hour stated above.

Immediate cause of death \_\_\_\_\_

7. Birth date of deceased: (Month) (Day) (Year)

8. AGE: Years 54 Months 2 Days 13 If less than one year \_\_\_\_\_ hr. \_\_\_\_\_ min.

Due to \_\_\_\_\_

Due to \_\_\_\_\_

9. Birthplace: (City, town, or county) \_\_\_\_\_ (State or foreign country) \_\_\_\_\_

Other conditions: (Include pregnancy within 3 months of death) \_\_\_\_\_

10. Usual occupation \_\_\_\_\_

Major findings: Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

11. Industry or business \_\_\_\_\_

12. Name \_\_\_\_\_

13. Birthplace: (City, town, or county) \_\_\_\_\_ (State or foreign country) \_\_\_\_\_

14. Maiden name \_\_\_\_\_

15. Birthplace: (City, town, or county) \_\_\_\_\_ (State or foreign country) \_\_\_\_\_

16. (a) Informant \_\_\_\_\_

(b) Address \_\_\_\_\_

17. (a) \_\_\_\_\_ (b) Date thereof: (Month) (Day) (Year)

(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_

(b) Address \_\_\_\_\_

19. (a) 2-3-1940 (b) J.A. Anderson (Date received local registrar) (Registrar's signature)

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) \_\_\_\_\_

(b) Date of occurrence \_\_\_\_\_

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? \_\_\_\_\_

While at work? (Specify type of place) (e) Means of injury \_\_\_\_\_

23. Signature U. A. V. Pressnell (Physician)

Address Kennett

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

SUPPLEMENTARY

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.