

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

La Lemmon 18108

State File No.

Registrar's No.

Registration District No. 318

Primary Registration District No. 2001

421

1. PLACE OF DEATH:

(a) County Greene
(b) City or town Springfield
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution 604 E. Elm
(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

3. (a) PRINT FULL NAME Dr. John Porter Ferguson
8. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex male 5. Color or race white 6. (a) Single, widowed, married, divorced married

6. (b) Name of husband or wife Mary Virginia Ferguson 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased October 17, 1870
(Month) (Day) (Year)

8. AGE: Years 169 Months 6 Days 19 If less than one day hr. _____ min. _____

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

10. Usual occupation Physician

11. Industry or business _____

MOTHER FATHER
12. Name Thomas E. Ferguson
13. Birthplace _____
(City, town, or county) (State or foreign country)
14. Maiden name Mary W. Porter
15. Birthplace _____
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Dr. John P. Ferguson

(b) Address 604 E. Elm, City

17. (a) Burial (b) Date thereof 5-8-40
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Maple Park

18. (a) Signature of funeral director Clara Lohmeyer
(b) Address Springfield Mo.

19. (a) May 7 1940 (b) W. L. Handley
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Greene
(c) City or town Springfield
(If outside city or town limits, write "RURAL")
(d) Street No. 604 E. Elm
(If rural, give location)
(e) If foreign born, how long in U. S. A? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 6
year 1940 hour 6 minute 15 M.

21. I hereby certify that I attended the deceased from 4/1
_____, 1940 to 7/6, 1940;
that I last saw him alive on 7/6, 1940
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral hemorrhage Duration 1 da

Due to of 2 1/2

Other conditions A previous cerebral hemorrhage, with hemiplegia 1 yr
(Include pregnancy within 3 months of death)

Major findings: Of operations PHYSICIAN
Of autopsy _____
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? at 4
(Specify type of place) (e) Means of injury _____
While at work? _____
Signature J. B. Lemmon (M. D. or other) M. D.
Address Springfield, Mo. Date signed 7-7-40

EVERY CASE ON WRITING BLACK INK—MAKE 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.

1 X 1931

APR 8 1942

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.....

....., Registered Apprentice No.....
working under my personal supervision.

Signed..... *E. O. Hartney*
Licensed Embalmer No. *1767*
P. O. Address *Springfield*

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.

*