U. S. No. 2
Rev. 1—11-10-39
Rev. 5-1-40

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 33498

NOV 16 1940

Registration District No. 791

Primary Registration District No. 1003

Registrar's No. 8195

609

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

1. PLACE OF DEATH:

(a) County

(b) City or town St. Louis
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
En Route to City Hospital #1
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 3
(Specify whether
In this community
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County

(c) City or town St. Louis 25
(If outside city or town limits write "RURAL")

(d) Street No. 710 Pine St
(If rural, give location)

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

8. (a) PRINT FULL NAME Betty Jean Ferguson

8. (b) If veteran, name war

3. (c) Social Security No.

4. Sex Female

5. Color or race White

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

6. (b) Name of husband or wife

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

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

8. AGE: Years	Months	Days	If less than one day
Abt 40			hr. min.

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

10. Usual occupation Housework 9

11. Industry or business

FATHER
12. Name Unknown
13. Birthplace Unknown (City, town, or county) 9 (State or foreign country)

MOTHER
14. Maiden name Unknown
15. Birthplace Unknown (City, town, or county) (State or foreign country)

16. (a) Informant Jos Queen
(b) Address Coroners Office

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 5 1940 (Month) (Day) (Year)

(c) Place: burial or cremation Ft. Worth Texas

18. (a) Signature of funeral director Peetz Brothers

(b) Address 3029 Lafayette Ave

19. (a) OCT 2 1940 (Date received by local registrar) (b) J. F. Berchek (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 1st day October
year 1940 hour 12:30 minute A. M.

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	Duration
Fatty degeneration of Myocardium	
Due to Cardiac Hypertrophy	
Due to	
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations 93 C
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 Joseph M. Jensen (M. D. or other)
Address Deputy Coroner (Date signed)

(Licensed Embalmer's Statement on Reverse Side)

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 Frank A. Queen

Licensed Embalmer No. 2245

P. O. Address Mt. Town Me

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.