

FEB 25 1941

STANDARD CERTIFICATE OF DEATH

State File No. 4037

Registration District No. 746

Primary Registration District No. 5081

Registrar's No.

9000

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

1. PLACE OF DEATH:

(a) County Reynolds
(b) City or town Rural - Jackson Township
(c) Name of hospital or institution: 1
(d) Length of stay: In hospital or institution: 63.
In this community: 63.

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Reynolds
(c) City or town Rural Jackson Township
(d) Street No. 0
(e) If foreign born, how long in U. S. A.? years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 1 day 24
year 1941 hour 6 minute 30 A.M.

21. I hereby certify that I attended the deceased from 1/17-41
to 1/24 1941
that I last saw him alive on 1/24 1941
and that death occurred on the date and hour stated above.

Immediate cause of death: Pneumonia
Due to: Influenza
Due to:
Other conditions:
Major findings:
Of operations:
Of autopsy:

Table with 2 columns: Duration, PHYSICIAN. Duration: 7. PHYSICIAN: (Signature)

3. (a) PRINT FULL NAME Andrew Joshua Ferguson

3. (b) If veteran, name war: name war. 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 Ella Ferguson. 6. (c) Age of husband or wife if alive 60 years

7. Birth date of deceased: 8 - 17 - 1876

8. AGE: Years 64 Months 5 Days 7 If less than one day hr. min.

9. Birthplace: New Tenn. (City, town, or county) (State or foreign country)

10. Usual occupation: Farmer

11. Industry or business:

MOTHER FATHER { 12. Name: Stephen Ferguson
13. Birthplace: Tenn.
14. Maiden name: Don't know
15. Birthplace: Don't know

16. (a) Informant: Alfred Ferguson
(b) Address: Ellington, Mo.

17. (a) Burial (b) Date thereof: 1-25-41
(c) Place: burial or cremation: Sutterfield

18. (a) Signature of funeral director: Robert Grantham
(b) Address: Ellington, Mo.

19. (a) (Date received local registrar) (b) (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?
(d) Did injury occur in or about home, on farm, in industrial place, in public place?
(e) While at work? (Specify type of place) (e) Means of injury
23. Signature: J. J. Hall (M. D. or other)
Address: Ellington, Mo. Date signed: 1/24-41

RECEIVED

District Health Officer No. 5,

District File Number 241225

Date Filed -----

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**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.....

Licensed Embalmer No.....

P. O. Address.....

**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.**

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 4037

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

Registration District No. 746

Primary Registration District No. 5981

Registrar's No.

1. PLACE OF DEATH:

(a) County Reynolds  
(b) City or town Jackson T.P.  
(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)

3. (a) PRINT FULL NAME

Andrew Joshua Ferguson

(b) If veteran, name war

(c) Social Security No.

4. Sex m

5. Color or race w

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

6. (b) Name of husband or wife

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

7. Birth date of deceased

(Month)

(Day)

(Year)

8. AGE:

Years

Months

Days

If less than one day

64

2

7

hr

min

9. Birthplace

(City, town, or county)

(State or foreign country)

10. Usual occupation

11. Industry or business

MOTHER FATHER { 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)

(Date received local registrar)

(Registrar's signature)

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 1 day 24  
year 1945 hour minute M.

21. I hereby certify that I attended the deceased from  
19 to 19

that I last saw him alive on  
and that death occurred on the date and hour stated above.

Immediate cause of death

Due to

Due to

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations

Of autopsy

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 T.P. Balla (M. D. or other)

Address Ellington Date signed

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

SUPPLEMENTAL COPY

RECEIVED

District Health Officer No. 5,

District File Number. 441495

Date Filed \_\_\_\_\_