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7-39
K23159

MAR 25 1941 791
Registration District No.

Primary Registration District No. **1003**

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

1. PLACE OF DEATH:

(a) County _____
(b) City or town **St. Louis, Missouri**
(c) Name of hospital or institution:
3433 Magnolia Ave.,
(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 **Mary Ferry**

3. (b) If veteran, name war **None** 3. (c) Social Security No. **None**

4. Sex **Female** 5. Color or race **White** 6. (a) Single, widowed, married, divorced **Widowed**

6. (b) Name of husband or wife **John Ferry** 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased **September 17, 1872**
(Month) (Day) (Year)

8. AGE: Years **68** Months **5** Days **9** If less than one day _____ hr. _____ min.

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

10. Usual occupation **Housewife**

11. Industry or business **At Home**

12. Name **Michael Kennedy**

13. Birthplace **Missouri**
(City, town, or county) (State or foreign country)

14. Maiden name **Corneal Kennedy**

15. Birthplace **Kansas**
(City, town, or county) (State or foreign country)

16. (a) Informant **Mrs. James Sanders**

(b) Address **3433 Magnolia Ave**

17. (a) **Burial** (b) Date thereof **3-1941**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Mt. Olive Cemetery**

18. (a) Signature of funeral director **Southern Funeral Home**

(b) Address **6322 S. Grand Blvd**

19. (a) **FEB 27 1941** (b) **[Signature]**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County _____
(c) City or town **St. Louis,**
(If outside city or town limits, write "RURAL") **17**
(d) Street No. **3433 Magnolia Ave.,**
(If rural, give location) **0**
(e) If foreign born, how long in U. S. A. ? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **February** day **26**
year **1941** hour _____ minute **8:30 a. M.**

21. I hereby certify that I attended the deceased from **Dec 1940**
_____ 19____, to **Feb 26** 19**41**;

that I last saw him alive on **Feb. 26** 19**41**;
and that death occurred on the date and hour stated above.

Immediate cause of death
**Chronic Cardiac Valvular Disease
& Hypertension**

Due to _____

Due to _____

Other conditions _____
(Include pregnancy within 3 months of death)

Major findings:
Of operations _____

Of autopsy _____

Duration

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 **D**

23. Signature **R. Berg** (M. D. or other) _____

Address **2253 Nebraska** Date signed **2/26/41**

Dr. Berg.
2253 Nebraska
3 to 5 P.m.

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 Virgil L. Derryman
Licensed Embalmer No. 4018
P. O. Address St. Louis Mo.

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, fact should be so stated above.