

S. No. 2  
M-5-42  
v. 5-17-39  
X32873

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

35365

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

Registration District No. 318

Primary Registration District No. 1003

Registrar's No. 9941

1. PLACE OF DEATH:  
(a) County \_\_\_\_\_  
(b) City or town St. Louis, MO  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
BARNES HOSPITAL  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 11-23-42 to 11-28-42  
(Specify whether  
In this community \_\_\_\_\_  
years, months or days)

2. USUAL RESIDENCE OF DECEASED:  
(a) State Ill (b) County 11  
(c) City or town Edwardsville 0 NR  
(If outside city or town limits, write "RURAL")  
(d) Street No. 117 S Kansas  
(If rural, give location)  
(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country 2

3. (a) PRINT FULL NAME Mr Robert Shields Ferguson  
(b) If veteran, World War name war 1: no 1  
(c) Social Security No. \_\_\_\_\_

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month Nov day 28<sup>th</sup>  
year 1942 hour 9 minute 40 P. M.  
21. I hereby certify that I attended the deceased from 11-23-  
\_\_\_\_\_, 1942 to 11-28, 1942  
that I last saw him alive on 11-28, 1942  
and that death occurred on the date and hour stated above.

4. Sex M | 5. Color or race W | 6. (a) Single, widowed, married, divorced married  
6. (b) Name of husband or wife Benerine Ferguson 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
7. Birth date of deceased Jan 7 1888  
(Month) (Day) (Year)

Immediate cause of death Sulphadiazine intoxication *Duration*  
Due to \_\_\_\_\_  
Due to \_\_\_\_\_  
Other conditions Bronchial Asthma  
(Include pregnancy within 3 months of death)

8. AGE: Years 54 Months 10 Days 21 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.  
9. Birthplace Canton Ohio  
(City, town, or county) (State or foreign country)  
10. Usual occupation merchant  
11. Industry or business Tavern

Major findings:  
Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_  
PHYSICIAN \_\_\_\_\_  
Underline the cause to which death should be charged statistically.

MOTHER: FATHER: {  
12. Name Edward Ferguson  
13. Birthplace Canton Ohio  
(City, town, or county) (State or foreign country)  
14. Maiden name Cora Shields  
15. Birthplace Canton Ohio  
(City, town, or county) (State or foreign country)  
16. (a) Informant Mrs Benerine Ferguson  
(b) Address Edwardsville Ill  
17. (a) Removal (b) Date thereof Dec 2 1942  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation Valley View Cem Edwardsville Ill  
18. (a) Signature of funeral director Frank E. Funeral Home  
(b) Address Edwardsville Ill  
19. (a) NOV 30 1942 (b) J. F. Brudak  
(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?  
\_\_\_\_\_  
(Specify type of place)  
- While at work? \_\_\_\_\_ (e) Means of injury \_\_\_\_\_  
23. Signature F R Bradley (M. D. or D.O.)  
Address BARNES HOSPITAL Date signed 11-29-42

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

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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.....

*John Katter*

Licensed Embalmer No. 3880

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, fact should be so stated above.**