

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED OCT 7 1943

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

31504

State File No. _____

Registration District No. 118

Primary Registration District No. 5439

Registrar's No. 52

1. PLACE OF DEATH:

(a) County Gasconade
(b) City or town Oak Hill, (Rural) Brookfield
(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 78 years. (Specify whether years, months or days)
In this community _____

3. (a) PRINT FULL NAME JOHN FRANKLIN FERRIS

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

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Widower

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

7. Birth date of deceased August 11, 1865
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
78 1 1 hr. min.

9. Birthplace Franklin Co. Missouri
(City, town, or county) (State or foreign country)

10. Usual occupation Retired Farmer

11. Industry or business Farming

12. Name John Ferris

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

14. Maiden name Martha Brown
(City, town, or county) (State or foreign country)

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

16. (a) Informant Dr. R. J. Ferris

(b) Address Sullivan, Missouri.

17. (a) Burial (b) Date thereof Sep. 15, 43
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Oak Hill Missouri

18. (a) Signature of funeral director Thos. P. Shaffer

(b) Address Sullivan, Missouri.

19. (a) Sep. 12, 1943 (b) Myrtle M. Wenkel
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Gasconade
(c) City or town Oak Hill (Rural)
(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 Sep. day 12
year 1943 hour 9 minute 30 A.M.

21. I hereby certify that I attended the deceased from Died without
without medical attention, 19____;

that I last saw him alive on _____, 19____;

and that death occurred on the date and hour stated above.

Immediate cause of death _____ Duration _____

Probably apoplexy

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 W. L. Jeter, Coroner or other D. O.

Address Hermann, Mo. Date signed 9/15/43

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

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.....

Edgar W. Laffoon

Licensed Embalmer No..... *3394*

P. O. Address..... *Sullivan 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, above space should be left blank.