

FILED JAN 26 1944
Registration District No. 38

Primary Registration District No. 5655

Registrar's No. 11

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

1. PLACE OF DEATH:
 (a) County Lawrence
 (b) City or town Mount Vernon
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
Missouri State Sanatorium
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 496 days
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:
 (a) State Missouri (b) County Jackson
 (c) City or town Kansas City
(If outside city or town limits, write "RURAL")
 (d) Street No. _____
(If rural, give location)
 (e) Citizen of foreign country? _____ (Yes or No)
 If yes, name country _____

3. (a) PRINT FULL NAME Katherine Ferron
 (b) If veteran, name war No
 (c) Social Security No. None known

MEDICAL CERTIFICATION
 20. DATE OF DEATH: Month January day 17th
 year 1944 hour 9 minute 50 A. M.

4. Sex Female 5. Color or race White
 6. (a) Single, widowed, married, divorced Single
 (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
 7. Birth date of deceased: Sept. 12th 1910
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from Sept. 9 1942 to Jan. 17 1944; that I last saw h. or alive on Jan 17 1944; and that death occurred on the date and hour stated above.

8. AGE: Years Months Days If less than one day
33 4 7 hr. _____ min.

Immediate cause of death Pulmonary tuberculosis Duration Over 2 yrs

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

Due to _____
 Due to _____
 Other conditions (include pregnancy within 3 months of death) 1381

10. Usual occupation Nursing

11. Industry or business _____

MOTHER FATHER {
 12. Name Peter Ferron
 13. Birthplace Fels France
(City, town, or county) (State or foreign country)
 14. Maiden name Katherine Kern
 15. Birthplace Boden Germany
(City, town, or county) (State or foreign country)

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

16. (a) Informant E. McMichael, Record Clerk

22. If death was due to external causes, fill in the following:

(b) Address Missouri State San. Mt. Vernon, Mo

(a) Accident, suicide, or homicide (specify) _____

17. (a) Removal (b) Date thereof July 18-19
(Burial, cremation, or removal) (Month) (Day) (Year)

(b) Date of occurrence _____

(c) Place: burial or cremation Falls City, Nebraska

Where did injury occur? _____
(City or town) (County) (State)

18. (a) Signature of funeral director Geo B Orr

(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

(b) Address Mt Vernon, Mo

While at work? _____ (Specify type of place)
 (c) Means of injury _____

19. (a) 1-18-43 (b) Andy Crawford
(Date received local registrar) (Registrar's signature)

23. Signature Ethel E. Coffman (M. D. _____)
 Address Mount Vernon, Mo Date signed Jan 17 44

RECEIVED

District Health Officer No. 6

District File Number 144-79

Date Filed JAN 24 1944

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 *Geo. B. Orr*

Licensed Embalmer No. *946*

P. O. Address *Mr. Vernon, 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.