V. S. No. 2
00M—8-43
ev. 5-17-39
I X37823

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED SEP 8 1944

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 26208

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 7330

1. PLACE OF DEATH:
(a) County City Hospital
(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: City Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution Died upon arrival (Specify whether
In this community 3 months years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State North Dakota (b) County
(c) City or town Park River
(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 Ruth Catherine Ferguson
3. (b) If veteran, name war No
3. (c) Social Security No. None
4. Sex Female
5. Color or race White
6. (a) Single, widowed, married, divorced Single
6. (b) Name of husband or wife —
6. (c) Age of husband or wife if alive years
7. Birth date of deceased April (Month) 24 (Day) 1904 (Year)
8. AGE: Years 40 Months 3 Days 28 If less than one day hr. min.
9. Birthplace Park River, North Dakota (City, town, or county) (State or foreign country)
10. Usual occupation Social Worker
11. Industry or business Social Security Commission
FATHER
12. Name John Ferguson
13. Birthplace Unknown (City, town, or county) (State or foreign country)
MOTHER
14. Maiden name Catherin Johnston
15. Birthplace Unknown (City, town, or county) (State or foreign country)
16. (a) Informant Catherine Ferguson
(b) Address Park River, N.D.
17. (a) Removal (Burial, cremation, or removal) (b) Date thereof Aug. 23, 1944 (Month) (Day) (Year)
(c) Place: burial or cremation Park River N.D.
18. (a) Signature of funeral director Alexander and Sons
(b) Address 6175 Delmar Blvd
19. (a) AUG 23 1944 (Date received local registrar) J. F. Bredeck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug. day 21 year 1944 hour 12 minute 45 P.M.
21. I hereby certify that I attended the deceased from , 19, to , 19;
that I last saw h. alive on , 19;
and that death occurred on the date and hour stated above.

Immediate cause of death Sodium Pentothal
Passing off administered at her home 5854 Cabanne
Due to Aug 22 1944 patient
from uremia while suffering
Due to temporary mental
alienation

Duration

Other conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operation 1630
Of autopsy

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) Suicide
(b) Date of occurrence Aug 22 1944
(c) Where did injury occur? St Louis (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? Home (Specify type of place)
While at work? — (e) Means of injury Barbiturate
23. Signature Alfred J. Perry (M. D. or other)
Address Deputy Coroner Date signed 8/23/44

(Licensed Embalmer's Statement on Reverse Side)

OCT 9 1944

JUN 5 1945

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 Jos. E McCullough

Licensed Embalmer No. 2460

P. O. Address 6175 Dellmar

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.