

1. PLACE OF DEATH:

(a) County Johnson
(b) City or town Warrensburg, Rural
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
RR. #4 Warrensburg, Mo
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution no
(Specify whether
In this community 50 Yrs
years, months or days)

3. (a) PRINT FULL NAME Archie Ferris

3. (b) If veteran, name war no 3. (c) Social Security No. 496-09-8448

4. Sex M 5. Color or race W 6. (a) Single, widowed, married, divorced single

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive 38 1/2 years

7. Birth date of deceased June 28 1906
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
57 3 13 hr. min.

9. Birthplace Pettis Co. Mo.
(City, town, or county) (State or foreign country)

10. Usual occupation Laborer

11. Industry or business _____

MOTHER FATHER { 12. Name Charley W. Ferris
13. Birthplace Ill
(City, town, or county) (State or foreign country)
14. Maiden name Virginia Goodwin
15. Birthplace Mt. Vernon Mo.
(City, town, or county) (State or foreign country)

16. (a) Informant Tom Ferris
(b) Address Warrensburg, Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-3-44
(Month) (Day) (Year)

(c) Place: burial or cremation Sunset Hill

18. (c) Signature of funeral director Sweeney Phillips
(b) Address Warrensburg, Mo.

19. (a) Sept 2 1944 (b) Lesla M. Williams
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Johnson
(c) City or town Rural
(If outside city or town limits, write "RURAL")
(d) Street No. RR #4 Warrensburg, Mo
(If rural, give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country U

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept day 2
year 1944 hour 2 minute A M.

21. I hereby certify that I attended the deceased from Aug 31, 1944, to Sept 2, 1944
that I last saw him alive on Sept 2, 1944
and that death occurred on the date and hour stated above.

Immediate cause of death Broncho-Pneumonia Duration 3 days

Due to _____

Due to _____

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

Major findings: Of operations _____
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) _____
(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. Williams M.D. (M. D. or other)
Address Warrensburg, Mo. Date signed Sept 2, 1944

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 *J. Carl Pient*.....

Licensed Embalmer No.....**3878**.....

P. O. Address **Warrensburg, 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.