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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 40658
Registrar's No. 1296

FILED DEC 29 1944

Registration District No. _____ Primary Registration District No. 1000

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

1. PLACE OF DEATH:

(a) County Buchanan
(b) City or town St. Joseph
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
2018 Francis St
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution none
(Specify whether
In this community 25 years
years, months or days)

3. (a) PRINT FULL NAME Lawrence Ferguson

3. (b) If veteran, name war no 3. (c) Social Security No. no

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 June 6 1881
(Month) (Day) (Year)

8. AGE: Years 63 Months 6 Days 15 If less than one day hr. min.

9. Birthplace Clarinda Iowa
(City, town, or county) (State or foreign country)

10. Usual occupation Laborer

11. Industry or business _____

MOTHER FATHER { 12. Name Unk
13. Birthplace Unk
(City, town, or county) (State or foreign country)
14. Maiden name unk
15. Birthplace unk
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs Isabelle Dilley

(b) Address 608 N 6th St, St. Joseph, Mo.

17. (a) Burial (b) Date thereof 12-23-44
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation City Cemetery

18. (a) Signature of funeral director Barry Funeral Home

(b) Address 224 South 10th St, St. Joseph,

19. (a) 12-23-44 (b) Shelton J. Chell
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Buchanan
(c) City or town St. Joseph
(If outside city or town limits, write "RURAL")
(d) Street No. 2018 Francis St
(If rural, give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month December day 21
year 1944 hour 4 minute 15 P.M.

21. I hereby certify that I attended the deceased from Nov 7
1944 to Dec 18 1944
that I last saw him alive on Dec 18 1944
and that death occurred on the date and hour stated above.

Immediate cause of death
Cerebral Thrombosis 3 days
Due to arteriosclerosis 50 yrs
Due to Senile Dementia 2 yrs

Other conditions
(Include pregnancy within 3 months of death)

Major findings: Of operations 836
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 8

23. Signature Charles H. Werner (M. D. or other) _____
Address 221 Kirkpatrick St _____
Date 12-23-1944

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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..... *Mollie E Sidenfaden Ho*
Licensed Embalmer No. *4235*
P. O. Address *St Joseph 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.