

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

1. PLACE OF DEATH

(a) County Jackson

(b) City or town Kansas City, Mo
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution 2530 Norton
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____ (Specify whether years, months or days)

In this community 55 yrs _____ (Specify whether years, months or days)

3. (a) PRINT FULL NAME George Robert Ferguson

3. (b) If veteran, name war none

3. (c) Social Security No. none

4. Sex MO 5. Color or race wh

6. (a) Single, widowed, married, divorced married

(b) Name of husband or wife Mattie Lee Ferguson

6. (c) Age of husband or wife if alive 68 years

7. Birth date of deceased Jan 3 1869
(Month) (Day) (Year)

8. AGE: Years 75 Months 7 Days 14 If less than one day hr. _____ min.

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

10. Usual occupation Retired Electric Inspector

11. Industry or business Armour Packing Co

12. Name Joseph Ferguson

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

14. Maiden name Susan Garnaud

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

16. (a) Informant Robert O Ferguson

(b) Address 221 2 E 69 Terrace

17. (a) 1119 (b) Date thereof 1119 45
(Burial, cremation, or removal) (Month) (Year)

(c) Place: burial or cremation Floral Hill

18. (a) Signature of funeral director Mrs. L. E. Foster

(b) Address KC Mo

19. (a) 1-18-45 (b) D. E. Brown
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson

(c) City or town Kansas City, Mo 3
(If outside city or town limits, write "RURAL")

(d) Street No. 2530 Norton 8
(If rural, give location)

(e) Citizen of foreign country? 0 (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan day 17 year 1945 hour 10 minute 25 P.M.

21. I hereby certify that I attended the deceased from Jan 14 1945 to Jan 17 1945; that I last saw him alive on Jan 16 1945 and that death occurred on the date and hour stated above.

Immediate cause of death Coronary Thrombosis Duration 3 days

Due to arterio sclerosis

Due to _____

Other conditions 94a
(Include pregnancy within 3 months of death)

Major findings: Of operations none

Of autopsy none

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) (a) Means of injury _____

23. Signature W. H. [unclear] M.D. (M. D. or other)

Address 1209 Webster Bldg Date signed 1/18/45

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..... *C. H. Wise*

Licensed Embalmer No. *2570*

P. O. Address..... *10 @ 5ms*

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.