

FILED MAY 21 1945

State File No.

Registration District No. 318

Primary Registration District No. 1003

Registrar's No. 4174

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

1. PLACE OF DEATH:

(a) County St. Louis  
(b) City or town St. Louis  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
Josephine Heikamp Hospital  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution. (Specify whether  
In this community \_\_\_\_\_ years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jefferson  
(c) City or town Danby  
(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 Cora Belle Ferguson

3. (b) If veteran, name war Nil 3. (c) Social Security No. None

4. Sex Female 5. Color or race White  
6. (a) Single, widowed, married, divorced Widow  
6. (b) Name of husband or wife Samuel Ferguson  
6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
7. Birth date of deceased November 7 1867  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
77 6 1 hr. min.

9. Birthplace Jefferson County Missouri  
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business \_\_\_\_\_

12. Name J. Hursev

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

14. Maiden name Sarah Warnick

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

16. (a) Informant Edna Sheperd

(b) Address Villa Allen St.

17. (c) Burial (b) Date thereof 5-12-45  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation Lebanon, Missouri

18. (a) Signature of funeral director Albert H. Hoppe

(b) Address 4700 Washington Blvd

19. (a) MAY 10 1945 (b) \_\_\_\_\_  
(Date received by Registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 8  
year 1945 hour 10:15 minute \_\_\_\_\_ P. M.

21. I hereby certify that I attended the deceased from July 5 -  
1945 to May 8 1945  
that I last saw her alive on May 8 1945  
and that death occurred on the date and hour stated above.

Immediate cause of death \_\_\_\_\_ Duration \_\_\_\_\_  
Cardiac exhaustion.  
Due to Choleperitis and  
Pericardial appandicitis.  
Due to Operative tube for  
May 5 - 1945

Other conditions: \_\_\_\_\_  
(Exclude pregnancy within 3 months of death)

Major findings: Choleperitis PHYSICIAN \_\_\_\_\_  
Of operations Pericardial appandicitis  
Of autopsy \_\_\_\_\_  
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 Dr. Fredrick M. D. (or other) \_\_\_\_\_  
Address 2115 S. Grand Date signed May 10 1945

MAY 25 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.....

*John Agonowski*

Licensed Embalmer No. *3398*

P. O. Address.....

**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.**