

FILED AUG 21 1945

Primary Registration District No.

1005

1. PLACE OF DEATH:

(a) County St. Louis Mo.  
(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: Alexian Brothers Hospital  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 5 days  
(Specify whether  
In this community \_\_\_\_\_  
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County \_\_\_\_\_  
(c) City or town St. Louis 17  
(If outside city or town limits, write "RURAL")  
(d) Street No. 8233 Reilly 91  
(If rural, give location)  
(e) Citizen of foreign country? No (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME MARTIN V. FERGUSON

3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. 50.0-16-4761

4. Sex male 5. Color or race white 6. (a) Single, widowed, married, divorced married  
6. (b) Name of husband or wife Emily Ferguson 6. (c) Age of husband or wife if alive 43 years  
7. Birth date of deceased Feb 14 1896  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
49 5 29 hr. min.

9. Birthplace St. Louis Mo. (City, town, or county) (State or foreign country)

10. Usual occupation Clerk

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

12. Name Matthew Ferguson

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

14. Maiden name Mrs. Rhine

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

16. (a) Informant Emily Ferguson

(b) Address 8233 Reilly

17. (a) burial (b) Date of death Aug 13 1945  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Mt Olive cemetery

18. (a) Signature of funeral director Helen Imberovich

(b) Address 5401 So Grand Blvd

19. (a) AUG 14 1945 (b) J. F. Ordeck  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug day 13 year 1945 hour 8 minute 20 M.

21. I hereby certify that I attended the deceased from Aug 13 1945 to Aug 13 1945  
that I last saw him alive on Aug 13 1945 and that death occurred on the date and hour stated above.

Immediate cause of death Intestinal obstruction Duration \_\_\_\_\_

Due to Carcinoma of colon with generalized metastasis  
Due to \_\_\_\_\_

Other conditions 46  
(Include pregnancy within 3 months of death)

Major findings: Of operations Carcinoma of colon with gangrene of infarcted colon Of autopsy and above  
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 June  
(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?

(Specify type of place) While at work? \_\_\_\_\_ (e) Means of injury 0

23. Signature J. H. Hayes (M. D. or other) MD  
Address 3606 N. Hayes Ave Date signed 8-14-45

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

MOTHER FATHER

**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 W. W. Wilkins  
Licensed Embalmer No. 3575

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.**