

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No.

FILED JAN 7 1947

Registration District No. 22

Primary Registration District No. 6095

Registrar's No. 66

1. PLACE OF DEATH: *Schuyler*

(a) County *Schuyler*

(b) City or town *Rural*

(c) Name of hospital or institution: *FABUS*

(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution *9 months* (Specify whether years, months or days)

In this community *9 months*

3. (a) PRINT FULL NAME *Lyle Emo Ferguson*

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

4. Sex *MO*

5. Color or race *W*

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

6. (b) Name of husband or wife _____

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

7. Birth date of deceased *April 3 1941*

(Month) (Day) (Year)

8. AGE: Years *5* Months *8* Days *23*

If less than one day hr. _____ min. _____

9. Birthplace *Lurey, Mo.*

(City, town or county) (State or foreign country)

10. Usual occupation _____

11. Industry or business _____

12. Name *Loren Ferguson*

13. Birthplace *Promise City, Iowa*

(City, town or county) (State or foreign country)

14. Maiden name *Etha M. Murray*

15. Birthplace *Russell, Iowa*

(City, town or county) (State or foreign country)

16. (a) Informant *Loren Ferguson*

(b) Address *Downing, Mo.*

17. (a) *Burial* (b) Date thereof *Dec. 26, 1946*

(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial *Memphis*

18. (a) Signature of funeral director *Lloyd Moore*

(b) Address *Downing, Mo.*

19. (a) *Dec. 27 1946* (b) *Mrs. A. J. Drake*

(Date received local register) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State *Mo.* (b) County *Schuyler*

(c) City or town *Rural*

(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 _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month *Dec 26* day *1946*

year *66* hour _____ minute *15* M.

21. I hereby certify that I attended the deceased from *Dec. 20* 1946 to *Dec. 25* 1946

that I last saw him alive on *Dec. 25* 1946

and that death occurred on the date and hour stated above.

Immediate cause of death *Heart Failure*

Due to *Double Pneumonia*

Due to *following Flu*

Duration _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings: *108*

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?

home (Specify type of place)

While at work? *✓* (c) Means of injury *✓*

23. Signature *H. E. Gering* (M. D. or other) _____

Address *Downing* Date signed *Dec 27 1946*

RECEIVED
District Health Officer No. 10
District File Number 147-25
Date Filed JAN - 6 1947

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 me
_____, Registered Apprentice No. _____
working under my personal supervision.

Signed Lloyd Moore

Licensed Embalmer No. 3151

P. O. Address Downing

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.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATHState File No. *Jan 1946*Registration District No. *325-*Primary Registration District No. *6095-*Registrar's No. *66*

1. PLACE OF DEATH:

- (a) County *Schuyler*
(b) City or town *Rural*
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:

(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)

3. (a) PRINT
FULL NAME *Lyle E. Ferguson*

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

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

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

7. Birth date of deceased *April 3 1942*
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day hr. min. *5 8 mo*

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

10. Usual occupation

11. Industry or business

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

16. (a) Informant

- (b) Address

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

- (c) Place: burial or cremation

18. (a) Signature of funeral director

- (b) Address

19. (a) *Dec 30 46* (b) *Mrs. J. J. Drake*
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

- (a) State (b) County
(c) City or town (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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month *Dec* Day *12* Year *1946* hour minute M.

21. I hereby certify that I attended the deceased from to 19; that I last saw him alive on 19; and that death occurred on the date and hour stated above. Immediate cause of death.

- Due to

- Due to

- Other conditions. (Include pregnancy within 3 months of death)

Major findings:

- Of operations

- Of autopsy

Duration

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?

(Specify type of place)

- While at work? (c) Means of injury

23. Signature (M. D. or other)

- Date signed

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