

UNITED STATES DEPARTMENT OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 11986
Registrar's No. 24

FILED MAY 4 1948
Registration District No. 24

Primary Registration District No. 5355

1. PLACE OF DEATH:

(a) County Dallas
(b) City or town Rural
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: X
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution X
In this community life (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Dallas 30
(c) City or town Rural 0
(If outside city or town limits, write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country X (1)

3. (a) PRINT FULL NAME Benjamin Thompson Ferrier

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

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Single

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

7. Birth date of deceased August - 1 - 1877
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
70 8 12 X hr. X min.

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

10. Usual occupation Farmer

11. Industry or business Farm

12. Name Jordan Ferrier

13. Birthplace Missouri 0
(City, town, or county) (State or foreign country)

14. Maiden name Nancy Jane Johnson

15. Birthplace Missouri 0
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Lucy Caywood (sister)

(b) Address Sterling, Kansas

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: 4-14-48
(Month) (Day) (Year)

(c) Place: burial or cremation Graceland-Sonway

18. (a) Signature of funeral director Alex Fainey

(b) Address Marshfield, Missouri

19. (a) 5/1/48 (Date received local registrar) (b) One J. B. Jones (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 13
year 1948 hour 2 minute A.M.

21. I hereby certify that I attended the deceased from 4-6, 1948 to 4-13, 1948
that I last saw him alive on 4-12, 1948
and that death occurred on the date and hour stated above.

Immediate cause of death Myocarditis
Due to Chronic Arthritis

Due to _____

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations _____

Of autopsy _____

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 0

23. Signature J. B. Jones (M. D. or other) MD

Address Cumway Date signed 5-15-48

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

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RECEIVED
District Health Officer No. 7,
District File Number 4-48-463
Date Filed 5-3-68

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 _____

Licensed Embalmer No. _____

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.