

FILED APR 21 1954

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **13412**

318

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|--|--|--|--|---|--|---|---|
| BIRTH NO. _____ | | REG. DIST. NO. _____ | | PRIMARY REG. DIST. NO. _____ | | Registrar's No. _____ | |
| 1. PLACE OF DEATH a. COUNTY _____ | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY _____ | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) St. Louis, Mo. | | c. LENGTH OF STAY (in this place) _____ | | c. CITY OR TOWN St. Louis | | d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/> | |
| d. FULL NAME OF HOSPITAL OR INSTITUTION 9142 Edna St. | | | | e. STREET ADDRESS (If rural, give location) 9142 Edna St. 2089 | | | |
| 3. NAME OF DECEASED (Type or Print) a. (First) MARY b. (Middle) _____ c. (Last) FERGUSON | | | 4. DATE OF DEATH (Month) (Day) (Year) April 6 1954 | | | | |
| 5. SEX Female | | 6. COLOR OR RACE White | | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed | | 8. DATE OF BIRTH July 16 | |
| 9. AGE (In years last birthday) 87 | | If UNDER 1 YEAR Months _____ Days _____ | | If UNDER 18 Hrs. _____ Mins. _____ | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unemployed | | | 10b. KIND OF BUSINESS OR INDUSTRY NONE | | 11. BIRTHPLACE (City and State or Foreign Country) Ireland | | 12. CITIZEN OF WHAT COUNTRY? USA |
| 13a. FATHER'S NAME Unknown | | | 13b. MOTHER'S MAIDEN NAME Unknown | | | 14. NAME OF HUSBAND OR WIFE Deceased | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give year or dates of service) NO | | 16. SOCIAL SECURITY NO. NONE | | 17. INFORMANT'S SIGNATURE OR NAME ADDRESS Bertrude Regan 9142 Edna St. | | | |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, ashenia, etc. It means the disease, injury, or complication which caused death. | | MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Arterio sclerotic heart disease ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. | | | | | INTERVAL BETWEEN ONSET AND DEATH 10 yrs. |
| 19a. DATE OF OPERATION _____ | | 19b. MAJOR FINDINGS OF OPERATION _____ | | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 21a. ACCIDENT SUICIDE HOMICIDE (Specify) _____ | | 21b. PLACE OF INJURY (e.g. in or about home, farm, factory, street, office bldg., etc.) _____ | | 21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) 420.0 | | | |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____ | | 21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21f. HOW DID INJURY OCCUR? _____ | | | |
| 22. I hereby certify that I attended the deceased from Jan 1952 to April 6, 1954 , that I last saw the deceased alive on April 1, 1954 , and that death occurred at 3 P. m., from the causes and on the date stated above. | | | | | | | |
| 23a. SIGNATURE M. J. Houck (Degree or title) MD | | | | 23b. ADDRESS 8902 Riverview Blvd. | | 23c. DATE SIGNED 4-7-54 | |
| 24a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | | 24b. DATE 4-9-54 | | 24c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery St. Louis Mo. | | 24d. LOCATION (City, town, or county) (State) Mo. | |
| DATE REC'D BY LOCAL REG. APR 8 1954 | | REGISTRAR'S SIGNATURE J. Carl Smith M.D. | | 25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS John Skycak & Son 5541 Riverview | | | |

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

S.P. (Licensed Embalmer's Statement on Reverse Side)

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, Student Embalmer No..... working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed *J. Allen Davis*.....
Licensed Embalmer No. *405*.....

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.