

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

6174

FILED FEB 25 1957

STATE FILE NUMBER

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. **928**

1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Mo.</i> b. COUNTY			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <i>St. Louis</i>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <i>St. Louis</i>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <i>2318 Franklin</i>			Length of stay in 1b	d. STREET ADDRESS (If outside, give location) <i>2318 Franklin Ave</i>			Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <i>Eugene</i> Middle <i>Ferguson</i> Last <i>Ferguson</i>				4. DATE OF DEATH Month <i>1</i> Day <i>24</i> Year <i>1957</i>			
5. SEX <i>Male</i>	6. COLOR OR RACE <i>Col.</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>Unknown</i>		9. AGE (In years last birthday) <i>Abt. 69</i> IF UNDER 1 YEAR: Months <i>1</i> Days <i>1</i> Hours <i>1</i> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Pool Room Operator</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Pool Room</i>		11. BIRTHPLACE (City and state or country) <i>Hopkinsville, Ky.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>	
13. FATHER'S NAME <i>James Ferguson</i>				14. MOTHER'S MAIDEN NAME <i>Ellie Harrison</i>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <i>No</i>			16. SOCIAL SECURITY NO. <i>—</i>	17. INFORMANT <i>Nora Bobson</i> Address <i>4305 Vernon Av. Chicago, Ill.</i>			
18. CAUSE OF DEATH [Enter only one cause and code for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral Thrombosis</i>							INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.							DUE TO (b) _____
							DUE TO (c) _____
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							19. WAS ALLOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) <i>420.1</i>				
20c. TIME OF INJURY Hour _____ Month _____ Day _____ Year _____ a. m. _____ p. m. _____							
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION		COUNTY STATE	
21. I attended the deceased from _____, to _____ and last saw her/him alive on _____. Death occurred at <i>354 P.</i> m on the date stated above; and to the best of my knowledge, from the causes stated.							
22. SIGNATURE (Deputy or third Deputy) <i>James M Kelly Coronor</i>				22b. ADDRESS <i>1300 Clark</i>		22c. DATE SIGNED <i>1-29-57</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE <i>1-30-1957</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Greenwood Cemetery</i>		23d. LOCATION (City, town, or county) (State) <i>St. Louis County, Mo.</i>		
24. FUNERAL DIRECTOR <i>Peoples Und. Co. 3100 Franklin Av.</i>				25. DATE RECD. BY LOCAL REG. <i>JAN 29 '57</i>		26. REGISTRAR'S SIGNATURE <i>J. Carl Smith M.D.</i> <i>L.P.</i>	

(Licensed Embalmer's Statement on Reverse Side)

ath, welfare, public service, 300, -56, Doctor, coroner, etc. must use only standard nomenclature in their reports. No symptoms or signs of disease or diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was em-
by me, or by, Student Embalmer No.....
working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed *W. Claude Gordon*

Licensed Embalmer No. *3*

P. O. Address *45 75 6*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (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.