

Health,
Welfare
Public
Service

300
1-56

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes.

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-006929
STATE FILE NUMBER

FILED MAR 5 - 1958

Registration District No. 316 Primary Registration District No. 6070 Registrar's No. 89

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USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

1. PLACE OF DEATH a. COUNTY <u>St. Francois</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>St. Francois</u>					
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. Francois Twp.</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		c. CITY OR TOWN <u>Wortham</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>State Hospital #4</u>			Length of stay in 1b <u>18y, 11m, 29d</u>		d. STREET ADDRESS (If outside, give location)		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <u>FRANCIS</u> Middle <u>(DORA)</u> Last <u>DORINE FERGUSON</u>				4. DATE OF DEATH Month <u>Feb.</u> Day <u>24</u> Year <u>1958</u>					
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Aug. 17, 1885</u>		9. AGE (In years last birthday) <u>72</u>	IF UNDER 1 YEAR Months <u>6</u> Days <u>7</u>	IF UNDER 24 HRS. Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housework</u>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) <u>Reynolds County, Mo.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
13. FATHER'S NAME <u>William Ferguson</u>				14. MOTHER'S MAIDEN NAME <u>Mary Rains</u>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>			16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT Address <u>Records, State Hospital #4, Farmington, Mo.</u>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Metastatic Carcinoma to liver and abdominal viscera</u>							INTERVAL BETWEEN ONSET AND DEATH <u>6 mos.</u>		
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.			DUE TO (b) <u>Carcinoma of the transverse colon</u>				<u>9 mos.</u>		
			DUE TO (c) <u>Dementia Praecox Psychosis</u>				<u>1531</u>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Abt. 30 yrs</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" 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.)						
20c. TIME OF INJURY Hour <u></u> Month <u></u> Day <u></u> Year <u></u> a. m. <u></u> p. m. <u></u>									
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 <u>Jan. 12, 1958</u> to <u>Feb. 24, 1958</u> and last saw her <u>alive</u> on <u>Feb. 24, 1958</u> . Death occurred at <u>2:05 P. M.</u> m on the date stated above; and to the best of my knowledge, from the causes stated.									
22a. SIGNATURE <u>John C. Brennan, M.D.</u> (Degree or title)				22b. ADDRESS <u>State Hospital No. 4 Farmington, Missouri</u>			22c. DATE SIGNED <u>2-24-58</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>Feb. 26, 1958</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Leadwood Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Leadwood, Missouri</u>				
24. FUNERAL DIRECTOR <u>Bert Boyer Funeral Home, Leadwood, Mo.</u> ADDRESS				25. DATE RECD. BY LOCAL REG. <u>Feb. 24, 1958</u>		26. REGISTRAR'S SIGNATURE <u>Ether Rudloff</u>			

(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 *William E. Boyer*

Licensed Embalmer No. *473*

P. O. Address *Leidwood*

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.