THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

59-013279

STATE FILE NUMBER

Registrar's No. 1770

Registration District No. 149 Primary Registration District No. 102

FILED APR 27 1959

1. PLACE OF DEATH
a. COUNTY Jackson
b. CITY OR TOWN Kansas City — Inside Limits Yes [X] No [ ]
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location) 602 Walnut — Length of stay in Hospital 30days

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Missouri b. COUNTY Jackson
c. CITY OR TOWN Kansas City — Inside Limits Yes [X] No [ ]
d. STREET ADDRESS (If outside, give location) 602 Walnut — Reside on Farm Yes [ ] No [X]

3. NAME OF DECEASED (Type or print) First DWIGHT Middle Last FERGUSON

4. DATE OF DEATH Month April Day 6 Year 1959

5. SEX Male

6. COLOR OR RACE White

7. MARRIED [ ] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [X]

8. DATE OF BIRTH Aug.26,1910

9. AGE (In years last birthday) 48 — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer

10b. KIND OF BUSINESS OR INDUSTRY Const.

11. BIRTHPLACE (City and state or country) Lowry City, Mo.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13a. FATHER'S NAME William Ferguson

13b. MOTHER'S MAIDEN NAME Mary Stock

14. NAME OF HUSBAND OR WIFE —

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) WW II

16. SOCIAL SECURITY NO. —

17. INFORMANT Ray Ferguson, Lowry City, Mo. Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Lobar Pneumonia — 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) 49CX

19. WAS AUTOPSY PERFORMED? YES [X] NO [ ]

20a. ACCIDENT [ ] SUICIDE [ ] HOMICIDE [ ]

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year

20d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]

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 _____ m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE Hugh H. Owens (Degree or title) Coroner — 22b. ADDRESS 1034 Rialto Bldg — 22c. DATE SIGNED 4-7-59

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial — 23b. DATE Apr.9,1959 — 23c. NAME OF CEMETERY OR CREMATORY Lowry City Cem. — 23d. LOCATION (City, town, or county) (State) Lowry City, Missouri

24. FUNERAL DIRECTOR Goodrich, Funeral Home Osceola, Mo. ADDRESS

25. DATE RECD. BY LOCAL REG. 4-7-59

26. REGISTRAR'S SIGNATURE Neva Marshall

All diseases in Part I must be causally related. USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

Hugh H. Owens

JUL 9 1959

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 .....

Licensed Embalmer No. 4275

P. O. Address K. C., Mo.

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.