

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-026278  
STATE FILE NUMBER

FILED VS JUL 27 1959

Registration District No. 310 Primary Registration District No. 3058 Registrar's No. 176

S. 300  
1-57

1. PLACE OF DEATH a. COUNTY <b>St. Charles</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Lincoln</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Charles</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>Elsberry</b>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>St. Joseph</b>		Length of stay in lb <b>10-DAYS</b>	d. STREET ADDRESS (If outside, give location) <b>514 No. Third St.</b>
3. NAME OF DECEASED (Type or print) First <b>Leighton</b> Middle <b>William</b> Last <b>Ferry</b>			4. DATE OF DEATH Month <b>July</b> Day <b>19</b> Year <b>1959</b>
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Whits</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Aug. 10, 1892</b>
9. AGE (In years last birthday) <b>66</b>		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Horse Trainer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Racing</b>	11. BIRTHPLACE (City and state or country) <b>Elsberry, Mo.</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13a. FATHER'S NAME <b>Clarence W. Ferry</b>	
13b. MOTHER'S MAIDEN NAME <b>Annie Robinson</b>		14. NAME OF HUSBAND OR WIFE <b>None</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <b>Yes World War II</b>		16. SOCIAL SECURITY NO. <b>496-14-8525</b>	
17. INFORMANT <b>Mrs. W.B. Ellis, Elsberry, Mo.</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Myocardial Infarction</b>			INTERVAL BETWEEN ONSET AND DEATH <b>10 days</b>
DUE TO (b) <b>Arteriosclerotic Coronary Artery Disease</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 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.) <b>4201</b>	
20c. TIME OF INJURY Hour _____ Month _____ Day _____ Year _____ a.m. _____ p.m. _____			
20d. INJURY OCCURRED WHILE AT <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 <b>July 9, 1959</b> to <b>July 19, '59</b> and last saw him alive on <b>July 19, 1959</b>		Death occurred at <b>3:50</b> p m on the date stated above; and to the best of my knowledge, from the causes stated.	
22a. SIGNATURE <b>Paul G. Rother MD</b> (Degree or title)		22b. ADDRESS <b>St Charles, Mo</b>	22c. DATE SIGNED <b>7-20-59</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>July 21, 1959</b>	23c. NAME OF CEMETERY OR CREMATORY <b>City Cemetery</b>	23d. LOCATION (City, town, or county) (State) <b>Elsberry MO.</b>
24. FUNERAL DIRECTOR <b>O'Saraulicko</b>	ADDRESS <b>Elsberry, Mo.</b>	25. DATE RECD. BY LOCAL REG. <b>July 21-59</b>	26. REGISTRAR'S SIGNATURE <b>Murella Wilson</b>

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

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.

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. *4012* .....

P. O. Address *Edsberry, 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.