

MURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

'59 0 4 3 9 0 0

Dr. Cochran

Registration District No. 128 Primary Registration District No. 2000 Registrar's No. 1418

STATE FILE NUMBER

FILED VS JAN - 4 1960

1. PLACE OF DEATH a. COUNTY <u>GREENE</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MISSOURI</u> b. COUNTY <u>WRIGHT</u>	
b. CITY (if outside corporate limits, give TOWNSHIP only) OR TOWN <u>SPRINGFIELD</u>		Length of stay in 1b <u>6 DAYS</u>	c. CITY OR TOWN <u>NORWOOD</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>BAPTIST HOSP.</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>BOX # 142</u> Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>RICHARD</u> Middle <u>L.</u> Last <u>FERGUSON</u>			4. DATE OF DEATH Month <u>DEC.</u> Day <u>28</u> Year <u>1959</u>				
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>5/2/95</u>	9. AGE (last birthday) <u>64</u>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>LETTER CARRIER</u>		11. BIRTHPLACE (City and state or country) <u>SWEETSPRINGS, MO.</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13a. FATHER'S NAME <u>JOHN FERGUSON</u>			13b. MOTHER'S MAIDEN NAME <u>OLIVE SIMMONS</u>		14. NAME OF HUSBAND OR WIFE <u>INEZ FERGUSON</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>YES W.W. # 1</u>			16. SOCIAL SECURITY NO.		17. INFORMANT Address <u>INEZ FERGUSON, NORWOOD, 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>Arteriosclerosis, Heart disease</u> <u>c acute massive myocardial infarct 6 days</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.] DUE TO (b) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown

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 _____ a.m. _____ p.m. Month, Day, Year _____		

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 <u>NORWOOD, MO.</u>	COUNTY _____ STATE _____
21. I attended the deceased from <u>12/22/59</u> to <u>12/28/59</u> and last saw her alive on <u>12/28/59</u> Death occurred at <u>1:40 P.M.</u> m on the date stated above, and to the best of my knowledge, from the causes stated.			

22a. SIGNATURE <u>Dr. Cochran M.D.</u> (Degree or title)		22b. ADDRESS <u>Springfield Mo</u>		22c. DATE SIGNED <u>12/29/59</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE <u>12/31/59</u>	23c. NAME OF CEMETERY OR CREMATORY <u>THOMAS CEMETERY</u>	23d. LOCATION (City, town, or county) <u>NORWOOD, MO.</u> (State)	

24. FUNERAL DIRECTOR <u>BARBER FUNERAL HOME, MT. GROVE, MO.</u>	ADDRESS	25. DATE RECD. BY LOCAL REG. <u>12-31-59</u>	26. REGISTRAR'S SIGNATURE <u>Effie S. Orleton</u>
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DOCUMENT
MEDICAL CERTIFICATION
BY AFFIDAVIT OF

STATEMENT BY LICENSED EMBALMER

JAN 1

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 W H McCann

Licensed Embalmer No. 2727
P. O. Address Springfield

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.