

FRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-004933

FILED VS MAR 7 1960

STATE FILE NUMBER

Registration District No. 1 Primary Registration District No. 3000 Registrar's No. 50

1. PLACE OF DEATH a. COUNTY Adair				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY Adair			
b. CITY (If outside corporate limits, give TOWNSHIP only) Kirksville		Length of stay in 1b 3 yrs		c. CITY OR TOWN Kirksville		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 413 W. Scott St.			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 413 W. Scott St.			Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First ANNA Middle GRAMLING Last FERGUSON				4. DATE OF DEATH Month Feb. Day 25 Year 1960			
5. SEX Female	6. COLOR OR RACE White	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH Aug 3/85	9. AGE (last birthday) 74	IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/>	IF UNDER 24 HR Hours <input type="checkbox"/> Min. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (City and state or country) Sullivan Co. Mo.		12. CITIZEN OF WHAT COUNTRY U S	
13a. FATHER'S NAME Wilkins Breeding		13b. MOTHER'S MAIDEN NAME Vena Neighbors		14. NAME OF HUSBAND OR WIFE Fred Ferguson			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, or unknown) (If yes, give No or dates of service) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Address Mildred Rusk, Geneseo, Illinois			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis						INTERVAL BETWEEN ONSET AND DEATH Minutes	
DUE TO (b) Influenza						Days	
DUE TO (c) Congestive Heart Failure						Years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Hypertension						PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" 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 <input type="checkbox"/> a.m. <input type="checkbox"/> 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		COUNTY	STATE
21. I attended the deceased from 8-16-57 to 2-25-60 and last saw her alive on 2-25-60 Death occurred at 11:07 p m on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) <i>Lyle P. Carter M.D.</i>				22b. ADDRESS Kirksville, Mo.		22c. DATE SIGNED 2-27-60	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE 2/28/60	23c. NAME OF CEMETERY OR CREMATORY Oakwoods		23d. LOCATION (City, county county) (State) Milan, Sullivan, Mo.			
24. FUNERAL DIRECTOR <i>Doris W. Raloff</i>		ADDRESS Foster Memorial Home, Kirksville, Mo.		25. DATE RECD. BY LOCAL REG. 2-27-1960	26. REGISTRAR'S SIGNATURE <i>Doris W. Raloff</i>		

DOCUMENT BY AFIDAVIT OF MEDICAL CERTIFICATION *Dr. Carter*

LYLE P. PARTIN, D.O.

0961

STATEMENT BY LICENSED EMBALMER

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

Student _____
Signature of Student Embalmer

Signed *Nova E. Foster*
Nova E. Foster

Licensed Embalmer No. 4742

P. O. Address Kirksville, Mo

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