

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-005079
STATE FILE NUMBER

Registration District No. 128 Primary Registration District No. 2000 Registrar's No. 116A

FILED VS FEB 20 1961

DATE AMENDED
INSTEAD OF
DOCUMENT
MEDICAL CERTIFICATION
SHOULD READ
BY AFFIDAVIT OF

| | | | |
|---|---|---|--|
| 1. PLACE OF DEATH a. COUNTY <u>Greene</u> | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo</u> b. COUNTY <u>Greene</u> | |
| b. CITY (if outside corporate limits, give TOWNSHIP only) OR TOWN <u>Springfield</u> | | Length of stay in 1b <u>2 wks</u> | c. CITY OR TOWN <u>Republic</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |
| c. FULL NAME OF (if NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>McMillian Rest Home</u> | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | d. STREET ADDRESS (if outside, give location) <u>_____</u> Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print) First <u>Edna</u> Middle <u>Bessie</u> Last <u>Ferguson</u> | | | 4. DATE OF DEATH Month <u>Jan.</u> Day <u>29</u> Year <u>1961</u> |
| 5. SEX <u>female</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>11-9-1893</u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u> | 9. AGE (last birthday) <u>68</u> IF UNDER 1 YEAR Months _____ Days _____ IF UNDER 24 HR Hours _____ Min. _____ |
| 11. BIRTHPLACE (City and state or country) <u>Republic, Mo</u> | | 12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u> | |
| 13a. FATHER'S NAME <u>Thomas Wallace</u> | | 13b. MOTHER'S MAIDEN NAME <u>Nancy Wade</u> | 14. NAME OF HUSBAND OR WIFE <u>E. B. Ferguson</u> |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>_____</u> | | 16. SOCIAL SECURITY NO. <u>_____</u> | 17. INFORMANT <u>E. B. Ferguson</u> Address <u>Republic, 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>Cerebral Arteriosclerosis</u> | | | INTERVAL BETWEEN ONSET AND DEATH <u>2 w. yrs.</u> |
| 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) | | | 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 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 COUNTY _____ STATE _____ |
| 21. I attended the deceased from <u>1955</u> to <u>Jan 29, 1961</u> and last saw her alive on <u>Jan 2, 1961</u> Death occurred at <u>2:30 A.M.</u> on the date stated above, and to the best of my knowledge, from the causes stated. | | | |
| 22a. SIGNATURE <u>[Signature]</u> (Degree or title) <u>M.D.</u> | | 22b. ADDRESS <u>Springfield, Mo.</u> | 22c. DATE SIGNED <u>2-10-61</u> |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | 23b. DATE <u>1-31-1961</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>Wade Cemetery</u> | 23d. LOCATION (City, town, or county) (State) <u>Republic Mo</u> |
| 24. FUNERAL DIRECTOR <u>W. B. Cantrell</u> ADDRESS <u>Republic, Mo</u> | | 25. DATE RECD. BY LOCAL REG. <u>2-13-61</u> | 26. REGISTRAR'S SIGNATURE <u>[Signature]</u> |

MAR 10 1961

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. Cottrell

Licensed Embalmer No. 4822

P. O. Address Republic, 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.