

SOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-044407

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. 141 Primary Registration District No. 3025 Registrar's No. 169

STATE FILE NUMBER

AMENDED

1. PLACE OF DEATH		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
a. COUNTY <u>Howell</u>		a. STATE <u>Mo.</u> b. COUNTY <u>Howell</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>West Plains</u>		c. CITY OR TOWN <u>West Plains</u>	
Length of stay in 1b mins. _____		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>Memorial Hosp.</u>		d. STREET ADDRESS (If outside, give location) <u>Lebo Rt.</u>	
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Cleo R. Ferguson</u>			4. DATE OF DEATH <u>12-25-1961</u>
5. SEX <u>M</u>			6. COLOR OR RACE <u>wht.</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>3-27-1912</u>
9. AGE (last birthday) <u>49 yrs.</u>			IF UNDER 1 YEAR IF UNDER 24 HR
			Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Wholesale veterinary shop</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>shop</u>	
11. BIRTHPLACE (City and state or country) <u>Oxford, Ark.</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13a. FATHER'S NAME <u>A.J. Ferguson</u>		13b. MOTHER'S MAIDEN NAME <u>Bertha Smith</u>	
14. NAME OF HUSBAND OR WIFE <u>Neva Morrison</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) _____		16. SOCIAL SECURITY NO. <u>yes</u>	
		INFORMANT <u>Mrs. Cleo Ferguson, West Plains, Mo</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). DEATH WAS CAUSED BY:			INTERVAL BETWEEN ONSET AND DEATH <u>13 hours</u>
PART I. IMMEDIATE CAUSE (a) <u>MYOCARDIAL INFARCTION</u>			
DUE TO (b) <u>ARTERIOSCLEROTIC HEART DIS.</u>			
DUE TO (c) _____			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>PREVIOUS MYOCARDIAL INFARCTION JUNE 1960</u>			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 _____	COUNTY _____ STATE _____
21. I attended the deceased from <u>1953</u> to <u>12-25-61</u> and last saw him alive on <u>12-25-61</u>			
Death occurred at <u>4:30 p.m.</u> on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <u>Jacob H. Wilson, M.D.</u>		22b. ADDRESS <u>West Plains, Mo.</u>	22c. DATE SIGNED <u>12-29-61</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>B</u>	23b. DATE <u>12-28-1961</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Oak Lawn Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>West Plains, Mo.</u>
24. FUNERAL DIRECTOR <u>Robertson's, West Plains, Mo.</u>		25. DATE RECD. BY LOCAL REG. <u>12-30-61</u>	26. REGISTRAR'S SIGNATURE <u>Beatrice Cook</u>

DATE AMENDED

INSTEAD OF

SIGNATURE SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

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. 3432

P. O. Address West Plains, 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.