

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-63-005196

STATE FILE NUMBER

DO NOT WRITE ON THIS STUD

AMENDED

Report for District No. FILED FEB 19 1963 Primary Registration District No. 4049 Registrar's No. 8

|   |   |   |   |
|---|---|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Boone</u>   |   | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>Missouri</u> b. COUNTY <u>Boone</u>                    |   |
| b. CITY (If outside corporate limits, give TOWNSHIP only)<br>OR TOWN <u>Centralia</u>   |   | Length of stay in 1b<br><u>2 Mo.</u>  | c. CITY OR TOWN <u>Centralia</u><br>Inside Limits<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>  |
| c. FULL NAME OF (If NOT in hospital, give location)<br>HOSPITAL OR INSTITUTION<br><u>Hickman Nursing Home</u>   |   | Inside Limits<br>Yes <input type="checkbox"/> No <input type="checkbox"/>   | d. STREET ADDRESS (If outside, give location)<br><u>Hickman Nursing Home</u><br>Reside on Farm<br>Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print)<br>First Middle Last<br><u>Cecil Ferguson</u>   |   | 4. DATE OF DEATH<br>Month Day Year<br><u>Feb 14 1963</u>  |   |
| 5. SEX<br><u>Male</u>   | 6. COLOR OR RACE<br><u>white</u>  | 7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/><br>Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH<br><u>Mar 27 1901</u>  |
| 9. AGE (last birthday)<br><u>60</u>   |   | IF UNDER 1 YEAR<br>Months Days<br><u>10 18</u>  | IF UNDER 24 HR<br>Hours Min.<br><u>10 18</u>  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Retired</u>   |   | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>Retired</u>   | 11. BIRTHPLACE (City and state or country)<br><u>Pettis County, Mo.</u>   |
| 12. CITIZEN OF WHAT COUNTRY<br><u>U.S.A.</u>  |   | 13a. FATHER'S NAME<br><u>Unknown</u>  |   |
| 13b. MOTHER'S MAIDEN NAME<br><u>Unknown</u>   |   | 14. NAME OF HUSBAND OR WIFE<br><u>Never Married</u>   |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give year or dates of service)<br><u>No</u>   |   | 17. INFORMANT<br>Address<br><u>Mrs. Edgar Hoover, Clinton, Mo</u>   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Hypostatic Pneumonia</u><br>DUE TO (b) <u>General debilitation</u><br>DUE TO (c) <u>mental condition</u><br>Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. |   |   | INTERVAL BETWEEN ONSET AND DEATH<br><u>6-8 hrs.</u><br><u>unknown</u>   |
| 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.<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown  |
| 19. WAS AUTOPSY PERFORMED?<br>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<br>Hour, a.m., p.m.<br>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<br>COUNTY STATE  |   |
| 21. I attended the deceased from <u>Dec-62</u> to <u>2-14-63</u> and last saw him alive on <u>2-14-63</u><br>Death occurred at <u>6:55 P.m.</u> on the date stated above, and to the best of my knowledge, from the causes stated.  |   |   |   |
| 22a. SIGNATURE (Degree or title)<br><u>A.C. Kelley M.D.</u>   |   | 22b. ADDRESS<br><u>Mexico, Mo</u>   | 22c. DATE SIGNED<br><u>2-15-63</u>  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Buried</u>  | 23b. DATE<br><u>2-16-1963</u>   | 23c. NAME OF CEMETERY OR CREMATORY<br><u>Clinton Cemetery</u>   | 23d. LOCATION (City, town, or county) (State)<br><u>Clinton, Mo.</u>  |
| 24. FUNERAL DIRECTOR<br>ADDRESS<br><u>Van Sant Funeral Home</u>   |   | 25. DATE RECD. BY LOCAL REG.<br><u>Feb 15 1963</u>  | 26. REGISTRAR'S SIGNATURE<br><u>Maud Mc Bride</u>   |

USE BLACK INK OR TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS INSTEAD OF

DATE AMENDED  
VS 300 Rev. 4/59  
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2/16/61  
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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 Paul J. Baller

Licensed Embalmer No. 4206

P. O. Address Centralia, 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.

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Permit issued Feb. 15<sup>th</sup> - 1963 - 57493