

## MISSOURI STATE BOARD OF HEALTH

## BUREAU OF VITAL STATISTICS

## CERTIFICATE OF DEATH

Do not use this space.

29438-a

## 1. PLACE OF DEATH

County ShannonRegistration District No. 1077File No. 29438-aTownship JasperPrimary Registration District No. 6081Registered No. 22

City..... (No.).....

St. .... Ward)

## 2. FULL NAME

(a) Residence. No. Jane Ferguson St., ..... Ward. ....

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 0 mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

## 3. SEX

F

## 4. COLOR OR RACE

W

## 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)

Widow

## 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

John Ferguson

## 6. DATE OF BIRTH (MONTH, DAY AND YEAR)

Nov. 2 - 1842

## 7. AGE

YEARS  
85MONTHS  
9DAYS  
25IF LESS than 1  
day, .... hrs.  
or .... min.

## 8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

Widow

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

## 9. BIRTHPLACE (CITY OR TOWN)

(STATE OR COUNTRY)

Georgia

## 10. NAME OF FATHER

Wm. Brown

## 11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY)

## 12. MAIDEN NAME OF MOTHER

## 13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY)

## PARENTS

## 14.

INFORMANT  
(Address)J. E. Ferguson  
Angeline MA

## 15.

FILED

8-27, 1928J. H. Waller

REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Aug-27- 1928

17.

I HEREBY CERTIFY, That I attended deceased from ..... 19....., to ..... 19....., 19....., to .....

that I last saw h. .... alive on ..... 19....., and that death occurred, on the date stated above, at ..... 1-33 a. m.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:

Hemiplegia820

(duration) yrs. mos. da.

CONTRIBUTORY  
(SECONDARY)

(duration) yrs. mos. da.

## 18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH.....

8 DID AN OPERATION PRECEDE DEATH?..... DATE OF.....

WAS THERE AN AUTOPSY?.....

WHAT TEST CONFIRMED DIAGNOSIS?

(Signed) Frank Boyd M. D.8-27, 1928 (Address) Eminee Mo

\*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

## 19. PLACE OF BURIAL, CREMATION, OR REMOVAL

DATE OF BURIAL

Spring Valley8-27-1928

## 20. UNDERTAKER

ADDRESS

Waller

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

