

**MISSOURI STATE BOARD OF HEALTH  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH**

Do not use this space.

30124

**1. PLACE OF DEATH**

County Franklin  
Township Buffalo  
City Franklin (No. \_\_\_\_\_) St. \_\_\_\_\_ Ward \_\_\_\_\_

Registration District No. 283  
Primary Registration District No. 3402

File No. \_\_\_\_\_  
Registered No. \_\_\_\_\_

**2. FULL NAME**

Thomas Franklin Ferguson

(a) Residence. No. \_\_\_\_\_ 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. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Married

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Nov 13 - 1890

7. AGE Years 38 Months 2 Days 12 If LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.

**8. OCCUPATION OF DECEASED**

(a) Trade, profession, or particular kind of work Farmer  
(b) General nature of industry, business, or establishment in which employed (or employer) \_\_\_\_\_  
(c) Name of employer \_\_\_\_\_

9. BIRTHPLACE (CITY OR TOWN) Franklin  
(STATE OR COUNTRY) Franklin Co. Mo.

PARENTS

10. NAME OF FATHER Jno. F. Ferguson

11. BIRTHPLACE OF FATHER (CITY OR TOWN) Franklin  
(STATE OR COUNTRY) \_\_\_\_\_

12. MAIDEN NAME OF MOTHER Mary L. Bird

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Franklin  
(STATE OR COUNTRY) \_\_\_\_\_

14. INFORMANT Mrs. M. Ferguson  
(Address) Franklin Mo. R. 1

15. FILED Dr. A. A. Rubin REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) Sept 2 1928

17. I HEREBY CERTIFY, That I attended deceased from only Sept 2, 1928 to 11, 1928 that I last saw him alive on Sept 19 and that death occurred, on the date stated above, at Franklin Mo.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:

Paralysis

CONTRIBUTORY (SECONDARY) \_\_\_\_\_ (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED Franklin

IF NOT AT PLACE OF DEATH, \_\_\_\_\_

DID AN OPERATION PRECEDE DEATH? No DATE OF \_\_\_\_\_

WAS THERE AN AUTOPSY? no only by history

WHAT TEST CONFIRMED DIAGNOSIS? none

(Signed) Dr. A. A. Rubin M. D.

, 19 1928 (Address) Franklin 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 Franklin Cemetery DATE OF BURIAL Sept 7 1928

20. UNDERTAKER Dr. A. A. Rubin ADDRESS \_\_\_\_\_

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.

37-9-19

STATE OF TEXAS  
COUNTY OF ...  
I, the undersigned, being a duly qualified Notary Public for the State of Texas, do hereby certify that the foregoing is a true and correct copy of the original as the same appears from the records of my office.

T

**MISSOURI STATE BOARD OF HEALTH  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH**

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

**1. PLACE OF DEATH**

County Franklin  
Township Buffalo  
City Buffalo (No. \_\_\_\_\_) (St. \_\_\_\_\_) (Ward \_\_\_\_\_)

Registration District No. 983  
Primary Registration District No. 5402

File No. \_\_\_\_\_  
Registered No. \_\_\_\_\_

**2. FULL NAME**

(a) Residence. No. \_\_\_\_\_ 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. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

Thomas Franklin Gergerson

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) M

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Nov 13 - 1890

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.  
37 10 20

**8. OCCUPATION OF DECEASED**

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

10. NAME OF FATHER

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)

14.

INFORMANT (Address)

15.

FILED \_\_\_\_\_, 19 \_\_\_\_\_

E. S. Newson  
REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) Sept 2 19 28

17. I HEREBY CERTIFY That I attended deceased from \_\_\_\_\_, 19\_\_\_\_, that I last saw him \_\_\_\_\_, 19\_\_\_\_, and that death occurred, on the date stated above, at \_\_\_\_\_.

**THE CAUSE OF DEATH WAS AS FOLLOWS:**

Analisis agitante

CONTRIBUTORY (SECONDARY) (duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

(duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH \_\_\_\_\_

DID AN OPERATION PRECEDE DEATH? DATE OF \_\_\_\_\_

WAS THERE AN AUTOPSY? \_\_\_\_\_

WHAT TEST CONFIRMED DIAGNOSIS? \_\_\_\_\_

(Signed) \_\_\_\_\_, M. D.

, 19 (Address)

\*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

19

20. UNDERTAKER

ADDRESS

Information should be carefully supplied. Physicians should state plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

**SUPPLEMENTARY**

S-30/24