



STATE OF NEW JERSEY

OFFICE OF THE REGISTRAR OF VITAL STATISTICS
OF THE BOROUGH OF PAULSBORO, GLOUCESTER COUNTY

This is to certify that the following is correctly copied from the record of death on file in my office.

New Jersey State Department of Health
CERTIFICATE OF DEATH

REG-18
Jun 91

STATE USE ONLY

| | | | | | | | |
|--|------------------------------|---|--|--|--|--|--|
| 1 NAME OF DECEASED (First) Thomas G. J. Ferguson | | (Middle) | | (Last) | | STATE USE ONLY | |
| 2 DATE OF DEATH 7-4-95 | 3 SEX M | 4 DATE OF BIRTH 5-11-26 | 5a AGE - Last Birth-day (yrs) 69 | 5b UNDER 1 YEAR Months Days Hours Minutes | 5c UNDER 1 DAY | | |
| 6 SOCIAL SEC. NO. 193-20-5130 | | 7a PLACE OF DEATH HOSPITAL: <input type="checkbox"/> INPATIENT <input type="checkbox"/> ER/OUTPATIENT <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> NURSING HOME <input checked="" type="checkbox"/> RESIDENCE <input type="checkbox"/> OTHER (Specify) | | | | | |
| 7b FACILITY NAME (if not institution, give street and no.) 8035 English Creek Ave. | | | 7c CITY/TOWN OR LOCATION Egg Harbor Twp. | | 7d COUNTY Atlantic | | |
| 8a RESIDENCE - (State) NJ | 8b COUNTY Atlantic | 8c CITY OR TOWN Egg Harbor Twp. | 8d STREET AND NUMBER 8035 English Creek Ave. | 8e INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | 8f ZIP CODE 08234 | | |
| 9 BIRTHPLACE (City & State, or Foreign Country) Phila., Pa. | | 10a DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 10b IF YES, WAR DATES (From/To) N/A | | 11 MARITAL STATUS <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED | |
| 12 SURVIVING SPOUSE (if Wife, Maiden Name) Elaine Dintaman | | 13 USUAL OCCUPATION (Kind of work done most of life, even if retired) Musician | | | 14 KIND OF BUSINESS OR INDUSTRY Music | | |
| 15 NAME AND ADDRESS OF LAST EMPLOYER Self Ferguson Music, Phila., Pa. | | | | | | | |
| 16 RACE <input checked="" type="checkbox"/> WHITE <input type="checkbox"/> BLACK | | 3 <input type="checkbox"/> AMER. INDIAN <input type="checkbox"/> OTHER (Specify): | | 17 OF HISPANIC ORIGIN? IF YES, SPECIFY: <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | 18 DECEDENT'S EDUCATION Highest Grade Completed 12 | |
| 19 NAME OF FATHER (First) (Middle) (Last) Andrew Ferguson | | 20 MAIDEN NAME OF MOTHER (First) (Middle) (Last) Anna Corrigan | | | | | |
| 21a NAME OF INFORMANT Elaine Ferguson | | | 21b RELATIONSHIP Wife | | 22a DISPOSITION <input type="checkbox"/> BURIAL <input checked="" type="checkbox"/> CREMATION <input type="checkbox"/> ENTOMBMENT <input type="checkbox"/> OTHER (Specify): | | |
| 22b NAME OF CEMETERY OR CREMATORY Eglinton Crematory | | | 22c CITY OR TOWN Clarksboro | | 22d STATE NJ | | |
| 23a NAME AND ADDRESS OF FUNERAL HOME Adams-Stiefel Funeral Home 203 West Broad Street, Paulsboro, NJ 08066 | | | | | | | |
| 23b SIGNATURE OF FUNERAL DIRECTOR <i>[Signature]</i> | | 23c N.J. LICENSE NO. 3725 | | 24a SIGNATURE OF LOCAL REGISTRAR <i>[Signature]</i> | | 24b DATE RECEIVED 7-5-95 | |
| 25a TIME OF DEATH 00:00-0500 AM | | 25b DATE AND HOUR PRONOUNCED DEAD DATE: 7/4/95 HOUR: 11:07 | | 25c TO THE BEST OF MY KNOWLEDGE, DEATH OCCURRED AT TIME, DATE, AND PLACE INDICATED. | | 25d DATE SIGNED A M | |
| Complete items 25c-d only when certifying physician is not available at time of death to certify cause of death. | | | | | | | |
| 26 PART I | | IMMEDIATE CAUSE (Enter the diseases, injuries or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.) a. PROBABLE CARDIAC ARREST | | | | INTERVAL BETWEEN ONSET AND DEATH — | |
| | | DUE TO OR AS A CONSEQUENCE OF: | | | | | |
| | | b. | | | | | |
| | | DUE TO OR AS A CONSEQUENCE OF: | | | | | |
| | | c. | | | | | |
| | | DUE TO OR AS A CONSEQUENCE OF: | | | | | |
| | | d. | | | | | |
| PART II Other significant conditions - contributing to death but not related to underlying cause in PART I ASTHMA | | | | | | | |
| 27 IF FEMALE, WAS SHE PREGNANT AT DEATH, OR ANY TIME 90 DAYS PRIOR TO DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO | | | | 28 WAS AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | | | |
| 29 DEATH DUE TO: <input checked="" type="checkbox"/> NATURAL <input type="checkbox"/> ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE | | <input type="checkbox"/> PENDING INVESTIGATION <input type="checkbox"/> COULD NOT BE DETERMINED | | 30b TIME OF INJURY M | | 30c INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
| 30d DESCRIBE HOW INJURY OCCURRED | | 30a PLACE <input type="checkbox"/> HOME <input type="checkbox"/> OFFICE BUILDING <input type="checkbox"/> FARM <input type="checkbox"/> FACTORY | | 30e LOCATION OF INJURY (Number and Street) | | 30f CITY AND COUNTY | |
| 30g STATE | | 31a NAME AND ADDRESS OF CERTIFIER W. E. Hooper Jr MD Somers Pt. NJ | | | | | |
| 31b TO THE BEST OF MY KNOWLEDGE, DEATH OCCURRED DUE TO CAUSES LISTED ABOVE. SIGNATURE OF CERTIFIER <i>[Signature]</i> | | 31c DATE SIGNED 7/5/95 | | | | 31d CERTIFYING PHYSICIAN <input type="checkbox"/> MEDICAL EXAMINER <input type="checkbox"/> PRONOUNCER AND CERTIFIER <input checked="" type="checkbox"/> | |

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Items 1 and 2 to be typed by Funeral Director

To be printed by Physician

TIME OF DEATH: 7/4/95

DATE OF DEATH: 7/4/95

NAME OF DECEASED AS KNOWN BY ATTENDING PHYSICIAN: THOMAS FERGUSON

PHYSICIAN - Please Print: THOMAS FERGUSON

STATE USE ONLY

IND. OCC.

CAUSE

PLACE OF ACC.

CROSS CLASS

H-4298



[Signature]
REGISTRAR OF VITAL STATISTICS
1211 Delaware St., Paulsboro, NJ
08066

DO NOT ACCEPT
UNLESS RAISED
SEAL IS AFFIXED
7/7/95
Date of Issue