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

PLACE OF DEATH

County Jasper

Township ~~Harrison~~ or Village or City Carthage (No. 322 Wiggins St.; Ward)

Registration District No. 408 File No. 26720

Primary Registration District No. 3020 Registered No. 106

[If death occurred in a hospital or institution, give its NAME instead of street and number]

FULL NAME Mary Wiggins

PERSONAL AND STATISTICAL PARTICULARS

SEX	COLOR OR RACE	SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)
Female	White	Widowed

DATE OF BIRTH: Aug (Month) 2 (Day) 1820 (Year)

AGE: 92 yrs. — mos. 3 ds. If LESS than 1 day, ___ hrs. or ___ min.?

OCCUPATION
(a) Trade, profession, or particular kind of work: Home Wife
(b) General nature of industry, business, or establishment in which employed (or employer): Retired

BIRTHPLACE (City or town, State or foreign country): W. Moreland Co. Penn.

PARENTS

NAME OF FATHER: Andrew Akins

BIRTHPLACE OF FATHER (City or town, State or foreign country): Penn.

MAIDEN NAME OF MOTHER: Elizabeth Zafaney

BIRTHPLACE OF MOTHER (City or town, State or foreign country): Penn

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) P. H. Wiggins

(ADDRESS) Carthage Mo.

Filed Aug 8, 1913. W E Steele REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH: Aug (Month) 6 (Day), 1913 (Year)

I HEREBY CERTIFY, that I attended deceased from Past 2 years, 191X, to Aug 6, 1913, that I last saw her alive on Aug 6, 1913, and that death occurred, on the date stated above, at 12.35 m.

The CAUSE OF DEATH* was as follows:

Senility

162

(Duration) Past 2 yrs to my Knowledge yrs. mos. ds.

Contributory (Secondary) (Duration) yrs. mos. ds.

(Signed) M. P. Gentry M. D.

Aug 7, 1913 (Address) Carthage Mo

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death ___ yrs. ___ mos. ___ ds. In the State ___ yrs. ___ mos. ___ ds.

Where was disease contracted if not at place of death?

Former or usual residence Carthage Mo

PLACE OF BURIAL OR REMOVAL: Park Cemetery

DATE OF BURIAL: Aug 7, 1913

UNDERTAKER: Reed Hud Co.

ADDRESS: Carthage Mo

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

MISSOURI STATE BOARD OF HEAL
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

PLACE OF DEATH

County_____

Township_____ Registration District No._____ File No._____
or
Village_____ Primary Registration District No._____ Registered No._____
or
City _____ (NO._____ St.;_____ Ward)

[If death occu
hospital or i
give its NAM
of street and n

FULL NAME_____

PERSONAL AND STATISTICAL PARTICULARS

SEX	COLOR OR RACE	SINGLE MARRIED WIDOWED OR DIVORCED (*Write* the word)

DATE OF BIRTH

_____, 1____
(Month) (Day) (Year)

AGE

_____yrs._____mos._____ds.

If LESS than 1 day, ____hrs. or ____min.?

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

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

BIRTHPLACE
(City or town, State or foreign country)

PARENTS

NAME OF FATHER

BIRTHPLACE OF FATHER
(City or town, State or foreign country)

MAIDEN NAME OF MOTHER

BIRTHPLACE OF MOTHER
(City or town, State or foreign country)

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)_____

(ADDRESS)_____

Filed _____, 191____ _____
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH

_____,
(Month) (Day)

I HEREBY CERTIFY, that I attended deceased
_____, 191____, to_____,
that I last saw h_____ alive on_____,
and that death occurred, on the date stated above, at____
The CAUSE OF DEATH* was as follows:

_____

_____

_____

_____(Duration)_____yrs._____mos.____

Contributory_____
(SECONDARY)

_____(Duration)_____yrs._____mos.____

(Signed)_____

_____, 191____ (Address)_____

*State the Disease Causing Death, or, in deaths from Violent Cau
(1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (FOR HOSPITALS INSTITUTIONS, TRANSIE
RECENT RESIDENTS)

At place of death____yrs.____mos.____ds. In the State____yrs.____mos.____

Where was disease contracted if not at place of death? _____

Former or usual residence_____

PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
UNDERTAKER	**ADDRESS**

qualify all diseases resulting from childbirth or mis-carriage, as "PUERPERAL *septichaemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, OR HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide;*

(b) *Grocery;* (a) *Foreman,* (b) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine,* etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework,* or *At home,* and

PLEASE WRITE PLAINLY in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.