WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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.

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

13411 5

PLACE OF DEATH

County: Cuttow

Township: Linn

or Village:

or City: (NO. St.; Ward)

Registration District No. 27 File No.

Primary Registration District No. 5736 Registered No. 51

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

FULL NAME Lena Sigers

PERSONAL AND STATISTICAL PARTICULARS

SEX: F

COLOR OR RACE: W

SINGLE MARRIED WIDOWED OR DIVORCED (Write the word): Single

DATE OF BIRTH: Nov 30, 1912 (Month) (Day) (Year)

AGE: 4 yrs. X mos. 1 ds. If LESS than 1 day, hrs. or min.?

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

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

BIRTHPLACE (City or town, State or foreign country): Neb

PARENTS

NAME OF FATHER: Henry Sigers

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

MAIDEN NAME OF MOTHER: Minnie Rougar

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

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant): Henry Sigers

(ADDRESS): Rush Hill Mo

Filed April 8, 1916. W E Corrett REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH: April (Month) 9 (Day), 1916 (Year)

I HEREBY CERTIFY, that I attended deceased from April 7, 1916, to April 9, 1916, that I last saw her alive on April 9, 1916, and that death occurred, on the date stated above, at 3 P m.

The CAUSE OF DEATH* was as follows:

Accidental Burns 181 167

(Duration) yrs. mos. 3 ds.

Contributory (SECONDARY) [illegible]

(Duration) yrs. mos. ds.

(Signed) W E Corrett M. D.

April 8, 1916. (Address) Rush Hill 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 X yrs. mos. ds. In the State X yrs. mos. ds.

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

Former or usual residence: usual residence

PLACE OF BURIAL OR REMOVAL: Rock Hill Church

DATE OF BURIAL: April 9, 1916

UNDERTAKER: Doolin

ADDRESS: Rush Hill Mo

PLACE OF DEATH

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

County _____

Township _____ Registration District No. _____ File No. _____

or

Village _____ Primary Registration District No. _____ Registered No. _____

or

City _____ (NO. _____, _____ St.; _____ Ward)

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

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

_____, *191*____
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from _____, 191____, to _____, 191____, that I last saw h_____ alive on _____, 191____, and that death occurred, on the date stated above, at _____ m.

The CAUSE OF DEATH* was as follows:

_____

_____

_____ (Duration) _____ yrs. _____ mos. _____ ds.

Contributory _____
(SECONDARY)

_____ (Duration) _____ yrs. _____ mos. _____ ds.

(Signed) _____ M. D.

_____, 191____ (Address) _____

*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 _____

PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
	_____, 191____
UNDERTAKER	ADDRESS

RI

County

Townshi
or
Village ..
or
City .....

Name of

Sex.....

Single, M

Date of

Age . . .

Occupat
Birthpla
(C

Name o
Birthpla
(C

Maiden
Birthpla
(C

Informa
Date Ce

Date of

Cause o
Contrib
Name o
Place of
Name o
Date of