

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

Do not use this space.

5987

1. PLACE OF DEATH

County DeKalb

Registration District No. 263

Township Adams

Primary Registration District No. 4162

City Weatherby (No. _____)

File No. _____

Registered No. 174

St. _____ Ward _____

2. FULL NAME

Jackie Don Wiglesworth

(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)

Single

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

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

11

7. AGE

YEARS

MONTHS

DAYS

If LESS than 1 day, _____ hrs. or _____ min.

3

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)

Weatherby, mo.

(STATE OR COUNTRY)

10. NAME OF FATHER

Oliver Wiglesworth

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY)

mo

12. MAIDEN NAME OF MOTHER

Faye Boyer

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY)

mo

14.

INFORMANT

Faye Boyer Wiglesworth

(Address)

Weatherby, mo

15.

FILED

Feb 10 1929

J. F. Hedrick, M.D.

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Feb 9 1929

17. I HEREBY CERTIFY, That I attended deceased from Feb 6, 1929 to Feb 9, 1929 that I last saw him alive on Feb 9, 1929, and that death occurred, on the date stated above, at 11 P. M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Jaundice

CONTRIBUTORY (SECONDARY)

1515 (duration) yrs. mos. ds.
160 (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH _____

19. DID AN OPERATION PRECEDE DEATH? DATE OF _____

WAS THERE AN AUTOPSY? _____

WHAT TEST CONFIRMED DIAGNOSIS?

(Signed) J. F. Hedrick, M. D.

7/10, 1929 (Address) Weatherby, 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

Altavista Cemetery

Feb 10 - 1929

20. UNDERTAKER

ADDRESS

John Boyer

Weatherby, mo.

PLAINLY, WITH THIS IS A PERMANENT RECORD

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

MAR 21 1929

PHARMACY

AT THE ...

**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 De Kalb Registration District No. 263
 Township _____ Primary Registration District No. 162 File No. _____
 City Weatherly (No. _____) St. _____ Ward _____ Registered No. 4

2. FULL NAME Jackie Don Wiglesworth
 (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

MEDICAL CERTIFICATE OF DEATH

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

16. DATE OF DEATH (MONTH, DAY AND YEAR) FEB 9 1929 19

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

17. I HEREBY CERTIFY That I attended deceased from _____, 19____ to _____, 19____ that I last saw h. _____ alive on _____, 19____, and that death occurred, on the date stated above, at _____ m.

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Feb 6 - 1929

THE CAUSE OF DEATH* WAS AS FOLLOWS:

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
3

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 _____

CONTRIBUTORY (SECONDARY)

9. BIRTHPLACE (CITY OR TOWN) _____ (STATE OR COUNTRY)

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.

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)

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

19

15.

FILED 3/10 1929

J. F. Hedrick
 REGISTRAR

20. UNDERTAKER

ADDRESS

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.

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

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