

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

**1985**  
Do not use this space.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state EXACTLY the CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

REC'D FEB 21 1939

**1. PLACE OF DEATH**

(a) County Clark Registration District No. 189  
 (b) Township Clay Primary Registration District No. 5283 Registered No. \_\_\_\_\_  
 (c) City \_\_\_\_\_ (d) Street No. \_\_\_\_\_ St. \_\_\_\_\_  
 (If death occurred in Hospital or Institution, write its name instead of street and number)  
 (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

**2. PRINT FULL NAME**

(a) Residence, No. 16 Henry Bigford (according to Keokuk Police records.)  
Kansas City, Mo. St. 11 (Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX Male 4. COLOR OR RACE Colored 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED W  
(Write the word)

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Don't know

7. AGE YEARS MONTHS DAYS Don't know If LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.

OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. \_\_\_\_\_  
 9. Industry or business in which work was done, as saw mill, bank, etc. \_\_\_\_\_  
 10. Date deceased last worked at this occupation (month and year) \_\_\_\_\_ 11. Total time (years) spent in this occupation \_\_\_\_\_

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Not known

FATHER 13. NAME Not known

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Not known

MOTHER 15. MAIDEN NAME Not known

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Not known

17. INFORMANT Keokuk Police records  
 (ADDRESS) gave no name

18. BURIAL, CREMATION, OR REMOVAL PLACE St. Paul Cemetery DATE Jan. 12, 1939

19. FUNERAL DIRECTOR (NAME) W. F. Kircher  
 (ADDRESS) Wayland, Mo.

20. FILED Jan 21 1939 W. F. Kircher  
 Local Registrar.

**MEDICAL CERTIFICATE OF DEATH**

21. DATE OF DEATH (MONTH, DAY, AND YEAR) January 11, 1939

22. I HEREBY CERTIFY That I attended deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_

I last saw h. \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_. Death is said to have occurred on the date stated above, at \_\_\_\_\_ m.

The principal cause of death and related causes of importance were as follows:

Killed by train  
Jan 12 about 8:15 AM  
Jan 11-1939  
L. B. G. K.

Date of onset

Other contributory causes of importance:

Name of operation \_\_\_\_\_ Date of \_\_\_\_\_  
 What test confirmed diagnosis? \_\_\_\_\_ Was there an autopsy? \_\_\_\_\_

23. If death was due to external causes (violence), fill in also the following:  
 Accident, suicide, or homicide? \_\_\_\_\_ Date of injury \_\_\_\_\_, 19\_\_\_\_

Where did injury occur? \_\_\_\_\_ (Specify city or town, county, and State)  
 Specify whether injury occurred in industry, in home, or in public place.

Manner of injury \_\_\_\_\_  
 Nature of injury \_\_\_\_\_

24. Was disease or injury in any way related to occupation of deceased? \_\_\_\_\_  
 If so, specify \_\_\_\_\_

(Signed) F. A. S. Rebo, M. D.  
 (Address) Wayland, Mo.

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RECEIVED

District Health Officer No. 10

District File Number 10-39-61

Date Filed FEB 14 1939

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, .....

*H. F. Kircher*

....., or by .....

Registered Apprentice No....., working under my personal supervision.

Signed.....

*H. F. Kircher*

Licensed Embalmer No. 2611

P. O. Address Wayland, J.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.

STATEMENT OF OCCURRENCE

FILL IN ANSWERS TO ALL SPACES  
CHECKED IN RED PENCIL.

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

1985.  
Do not use this space.

1. PLACE OF DEATH

(a) County Clark Registration District No. 189  
(b) Township Clay Primary Registration District No. 3270 Registered No. \_\_\_\_\_  
(c) City \_\_\_\_\_ (d) Street No. \_\_\_\_\_  
(If death occurred in Hospital or Institution, write its name instead of street and number)  
(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U.S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME

Henry Bigford (according to Keokuk Police Records)  
(a) Residence, No. \_\_\_\_\_ St.  (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX m 4. COLOR OR RACE col 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) \_\_\_\_\_

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Jan 11 1985

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

22. I HEREBY CERTIFY That I attended deceased from \_\_\_\_\_ 19\_\_\_\_ to \_\_\_\_\_ 19\_\_\_\_

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

I last saw h. \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_. Death is said to have occurred on the date stated above, at \_\_\_\_\_ m.

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.

The principal cause of death and related causes of importance were as follows:

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.  
9. Industry or business in which work was done, as saw mill, bank, etc.  
10. Date deceased last worked at this occupation (month and year) \_\_\_\_\_  
11. Total time (years) spent in this occupation \_\_\_\_\_

Killed by train

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

no. 72 southbound Jan 11 1985  
207 St.  
Date of onset 8:20 A.M.

FATHER 13. NAME

Other contributory causes of importance: \_\_\_\_\_

FATHER 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

Name of operation \_\_\_\_\_ Date of \_\_\_\_\_

MOTHER 15. MAIDEN NAME

What test confirmed diagnosis? \_\_\_\_\_ Was there an autopsy? \_\_\_\_\_

MOTHER 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

23. If death was due to external causes (violence), fill in also the following: Accident, suicide, or homicide? Registered Date of injury Jan 11, 1985

17. INFORMANT (ADDRESS)

Where did injury occur? near Alexandria Md. Blank  
(Specify city or town, county, and State)

18. BURIAL, CREMATION, OR REMOVAL

Specify whether injury occurred in industry, in home, or in public place.

PLACE \_\_\_\_\_ DATE \_\_\_\_\_ 19\_\_\_\_

Manner of injury fatally killed train

19. FUNERAL DIRECTOR (ADDRESS)

Nature of injury washed and skull crushed

20. FILED \_\_\_\_\_ 19\_\_\_\_ Local Registrar

24. Was disease or injury in any way related to occupation of deceased? yes

If so, specify F. S. Reed, M. D.

(Address) Alexandria Md.

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY REGISTRATION DISTRICT NO. 189

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

S-1985