

REC'D SEP 7 1939

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

28795
Do not use this space.

1. PLACE OF DEATH

(a) County Carroll Registration District No. 194
(b) Township Redigo Primary Registration District No. 4075
(c) City Bosworth mo or Redigo (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

Lizzie Riggs Cockayne
(a) Residence, No. _____ St. _____ (If nonresident, give city or town and State)
(Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX <u>Female</u>	4. COLOR OR RACE <u>white</u>	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) <u>widowed</u>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF <u>H. Cockayne</u>		
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) <u>Feb 25 - 1853</u>		
7. AGE	YEARS	MONTHS
	<u>84</u>	<u>0</u>
		7
	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. <u>Housework</u>	
	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) <u>Ill</u>		
FATHER	13. NAME <u>John S. Holliday</u>	
	14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Ill</u>	
MOTHER	15. MAIDEN NAME <u>Catherine Bugale</u>	
	16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Virginia</u>	
17. INFORMANT (ADDRESS) <u>Mrs. Boyd Riggs</u> <u>Bosworth mo</u>		
18. BURIAL, CREMATION, OR REMOVAL PLAC <u>Rock Branch Chrch</u> DATE <u>Aug 3</u> 19 <u>39</u>		
19. FUNERAL DIRECTOR (NAME) (ADDRESS) <u>David J. Edwards</u> <u>Bosworth mo</u>		
20. FILED <u>Aug 3</u> 19 <u>39</u> <u>Mrs. A. G. Brown</u> Local Registrar		

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Aug 2 193922. I HEREBY CERTIFY that I attended deceased from May 1937, to Aug 2, 1939I last saw her alive on Aug 2, 1939. Death is said to have occurred on the date stated above, at 9 A.M.
The principal cause of death and related causes of importance were as follows:Hemiplegia
with motor
paralysis

Date of onset

Other contributory causes of importance:

Name of operation _____ Date of _____
What test confirmed diagnosis? Clonus Was there an autopsy? No23. 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? No
If so, specify _____
(Signed) A. G. Brown M. D.(Address) Bosworth mo

822

RECEIVED
District Health Officer No. 8,
Date Recd. Number
9/5/39

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, or by.....

....., Registered Apprentice No.....

working under my personal supervision.

Signed *David H. Edwards*

Licensed Embalmer No. *3265*

P. O. Address *Bosworth, N. C.*

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.

FILL IN ANSWERS TO ALL SPACES
CHECKED IN RED PENCIL.

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

28795-
Do not use this space.

1. PLACE OF DEATH

(a) County Carroll Registration District No. 134
(b) Township _____ Primary Registration District No. 4075- Registered No. 15
(c) City Baseworth (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 Rizzie Riggs Cockayne

(a) Residence, No. _____ St. (If nonresident, give city or town and State)
(Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX <u>F</u>	4. COLOR OR RACE <u>W</u>	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) <u>and</u>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF		
6. DATE OF BIRTH (MONTH, DAY, AND YEAR)		
7. AGE	YEARS <u>84</u>	MONTHS <u>5-</u>
	DAYS <u>9</u>	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)		
FATHER	13. NAME	
	14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)	
MOTHER	15. MAIDEN NAME	
	16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)	
17. INFORMANT (ADDRESS)		
18. BURIAL, CREMATION, OR REMOVAL		
PLACE	DATE	19
19. FUNERAL DIRECTOR (ADDRESS)		
20. FILED _____ 19 _____		

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Aug 2 1939

22. I HEREBY CERTIFY, That I attended deceased from _____ 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:

Hepatic Spleenitis with partial gangrene

Date of onset _____

Other contributory causes of importance: Sequelae to Cerebral Hemorrhage

Name of operation _____ Date of _____

What test confirmed diagnosis Clinical 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) A. G. Jones Brown _____, M. D. (Address) Baseworth Mo

SUPPLEMENT

Local Registrar.

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

S-28795