

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

14727

State File No. \_\_\_\_\_

Registration District No. 299

Primary Registration District No. 4139

Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH:

(a) County Crawford  
 (b) City or town Bourbon  
 (If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution:  
Bome 2  
 (If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution \_\_\_\_\_  
 (Specify whether \_\_\_\_\_)  
 In this community \_\_\_\_\_  
 years, months or days)

8. (a) PRINT FULL NAME Martha West Isgrigg Reno

3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced: Widowed

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased: (Month) 3 (Day) \_\_\_\_\_ (Year) \_\_\_\_\_

8. AGE: Years 80 Months 0 Days 17 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace Missouri (City, town, or county) \_\_\_\_\_ (State or foreign country) \_\_\_\_\_

10. Usual occupation House wife

11. Industry or business \_\_\_\_\_

MOTHER FATHER { 12. Name John Isgrigg 1  
 13. Birthplace Tenn (City, town, or county) \_\_\_\_\_ (State or foreign country) \_\_\_\_\_

{ 14. Maiden name Caroline Deover 1  
 15. Birthplace Tenn (City, town, or county) \_\_\_\_\_ (State or foreign country) \_\_\_\_\_

16. (a) Informant Mrs. Maud Northcut  
 (b) Address Bourbon Mo

17. (a) \_\_\_\_\_ (b) Date thereof \_\_\_\_\_ (Month) (Day) (Year)  
 (Burial, cremation, or removal) \_\_\_\_\_  
 (c) Place: burial or cremation Higgins Cemetery

18. (a) Signature of funeral director Albert E. Sany  
 (b) Address Bourbon Mo

19. (a) May 1 46 (b) C.W. Adams 205  
 (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Crawford  
 (c) City or town Bourbon  
 (If outside city or town limits, write "RURAL")  
 (d) Street No. 0  
 (If rural, give location)  
 (e) If foreign born, how long in U. S. A.? \_\_\_\_\_ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 4 day 13  
 year 1940 hour 11 minute 45 A. M.

21. I hereby certify that I attended the deceased from 4-11, 1940, to 4-13, 1940;

that I last saw h. \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_; and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Hemorrhage  
Old age

Due to Clinical 928

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_  
 (Include pregnancy within 3 months of death)

Major findings: \_\_\_\_\_  
 Of operations None

Of autopsy no

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) \_\_\_\_\_

(b) Date of occurrence \_\_\_\_\_

(c) Where did injury occur? \_\_\_\_\_ (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? \_\_\_\_\_

While at work? \_\_\_\_\_ (Specify type of place) (e) Means of injury \_\_\_\_\_

23. Signature E. L. Hume (M. D. or other) \_\_\_\_\_

Address Bourbon Mo Date signed \_\_\_\_\_

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

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**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.....

**RECEIVED**  
Working under my personal supervision.

District Health Officer No. 5,

District File Number 540 601

Date Filed 5/7/40

Signed.....

Licensed Embalmer No.....

P. O. Address.....

**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.