

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. **33296**

Registration District No. **1024**

Primary Registration District No. **6088**

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

1. PLACE OF DEATH: *Shelby*  
(a) County. *Shelby*  
(b) City or town. *Shelbyville*  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution. *Rural - Tiger Fork township*  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution. \_\_\_\_\_ (Specify whether)  
In this community. *71 years*  
years, months or days

3. (a) PRINT FULL NAME *MINNIE ELIZABETH BIGELOW*

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

4. Sex *Female* 5. Color or race *White* 6. (a) Single, widowed, married, divorced. *Married*

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

7. Birth date of deceased *Feb. 28 1869*  
(Month) (Day) (Year)

8. AGE: Years *71* Months *6* Days *6* If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace *Shelby Co. Mo.* (City, town, or county) (State or foreign country)

10. Usual occupation *Housewife*

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

12. Name *William J. Parsons*

13. Birthplace *Va.* (City, town, or county) (State or foreign country)

14. Maiden name *Mary Elizabeth Pierce*

15. Birthplace *Va.* (City, town, or county) (State or foreign country)

16. (a) Informant *Roy Bigelow*

(b) Address *Shelbyville, Mo.*

17. (a) *Burial* (Burial, cremation, or removal) (b) Date thereof *9-6-1940* (Month) (Day) (Year)

(c) Place: burial or cremation *Mt. Zion Cemetery*

18. (a) Signature of funeral director *E. B. Thompson*

(b) Address *Shelbyville, Mo.*

19. (a) *Sept 6 1940* (b) *Wm C. Munngrave* (Date recorded local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State *Mo.* (b) County *Shelby*

(c) City or town *Rural* (If outside city or town limits, write "RURAL")

(d) Street No. \_\_\_\_\_ (If rural, give location)

(e) If foreign born, how long in U. S. A. \_\_\_\_\_ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month *Sept* day *4th* year *1940* hour *8* minute *30* P. M.

21. I hereby certify that I attended the deceased from *Sept 1* 19 *40* to *Sept 4* 19 *40*

that I last saw her alive on *Sept 4* 19 *40* and that death occurred on the date and hour stated above.

Immediate cause of death *Hemorrhage of Stomach* Duration *3 da*

Due to *Gastric Ulcers.*

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

Other conditions *11/1 W*  
(Include pregnancy within 3 months of death)

Major findings: Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

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? *Yes*

While at work? \_\_\_\_\_ (Specify type of place) (e) Means of injury *3*

23. Signature *A. L. Sumner* (M. D. or other) *DO*

Address *Shelbyville* Date signed *Sept 10*

RECEIVED

District Health Officer No. 10

District File Number 10-40-1864

Date Filed OCT 8 1940

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.....

*E. P. Thompson*

Licensed Embalmer No. 1632

P. O. Address Shelbyville

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, fact should be so stated above.