

FILED AUG 14 1942

Registration District No. **337**

Primary Registration District No. **4499**

Registrar's No. **78**

1. PLACE OF DEATH:

(a) County **Shelby Co**
 (b) City or town **Shelbina**
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution _____
 In this community **88 Years** (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Shelby** **102**
 (c) City or town **Shelbina** **2**
 (If outside city or town limits, write "RURAL") **0**
 (d) Street No. _____ (If rural, give location)
 (e) Citizen of foreign country? _____ (Yes or No)
 If yes, name country _____

3. (a) PRINT FULL NAME **Martha Ann Wiggins**

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... **Widowed**
 6. (b) Name of husband or wife **John Wiggins** 6. (c) Age of husband or wife if alive _____ years
 7. Birth date of deceased **Sept 13th 1851**
 (Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	90	10	9	hr. _____ min. _____

9. Birthplace **Illinois**
 (City, town, or county) (State or foreign country)

10. Usual occupation **At Home**

11. Industry or business _____

MOTHER FATHER { 12. Name **Noah Cadwell**
 13. Birthplace **Ill**
 (City, town, or county) (State or foreign country)
 14. Maiden name **Not Known**
 15. Birthplace **9**
 (City, town, or county) (State or foreign country)

16. (a) Informant **Bert Wiggins**
 (b) Address **Shelbina Mo.**

17. (a) **Burial** (b) Date thereof **7/23/42**
 (Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation **I.O.O.F. Shelbina Mo.**

18. (a) Signature of funeral director **Millie B. Baker**
 (b) Address **Shelbina Mo.**

19. (a) **July 29-42** (b) **Mudge Gooch**
 (Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **July** day **22**
 year **1942** hour **6** minute **P** M.
 21. I hereby certify that I attended the deceased from **July 20**
 19**42** to **July 22** 19**42**
 that I last saw h. **alive** on **July 20** 19**42**
 and that death occurred on the date and hour stated above.

Immediate cause of death _____
Uremic Poisoning **3 days**
acute nephritis **8 or 10 days**

Other conditions _____
 (Include pregnancy within 3 months of death)

PHYSICIAN
 Major findings:
 Of operations _____
 Of autopsy _____
 Underline the cause to which death should be charged statistically.

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 **R. L. Baldwin** (M.D. or other) **DO.**
 Address **Shelbina Mo.** Date signed **July 28**

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

1095

RECEIVED

District Health Officer No. 10

District File Number 8-42-1606

Date Filed AUG 13 1942

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 Henry G. Bergelee

Licensed Embalmer No. 3835

P. O. Address Shelburne, Mo.

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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 25480

Registration District No. 337

Primary Registration District No. 4499

Registrar's No. _____

1. PLACE OF DEATH:
 (a) County Shelby
 (b) City or town Shelbina
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution _____
(Specify whether
 In this community 8 1/2 yrs.
years, months or days)

3. (a) PRINT FULL NAME Mathie Ann Wiggins
 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 W
 6. (b) Name of husband or wife John 6. (c) Age of husband or wife if alive _____ years
 7. Birth date of deceased Sept 13 1895
(Month) (Day) (Year)

8. AGE: Years 90 Months 10 Days 22 if less than one day min.
 9. Birthplace _____
(City, town, or county) (State or foreign country)

10. Usual occupation _____
 11. Industry or business _____

MOTHER FATHER
 12. Name _____
 13. Birthplace _____
(City, town, or county) (State or foreign country)
 14. Maiden name _____
 15. Birthplace _____
(City, town, or county) (State or foreign country)

16. (a) Informant _____
 (b) Address _____
 17. (a) _____ (b) Date thereof _____
(Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation _____

18. (a) Signature of funeral director _____
 (b) Address _____
 19. (a) _____ (b) _____
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
 (a) State _____ (b) County _____
 (c) City or town _____
(If outside city or town limits, write "RURAL")
 (d) Street No. _____
(If rural, give location)
 (e) Citizen of foreign country? _____ (Yes or No)
 If yes, name country _____

MEDICAL CERTIFICATION
 20. DATE OF DEATH: Month July Day 12 Year 1982 Hour _____ Minute _____ M.
 21. I hereby certify that I attended the deceased from _____ 19____;
 that I or saw him _____ alive on _____ 19____;
 and that death occurred on the date and hour stated above.
 Immediate cause of death Memorie poisoning

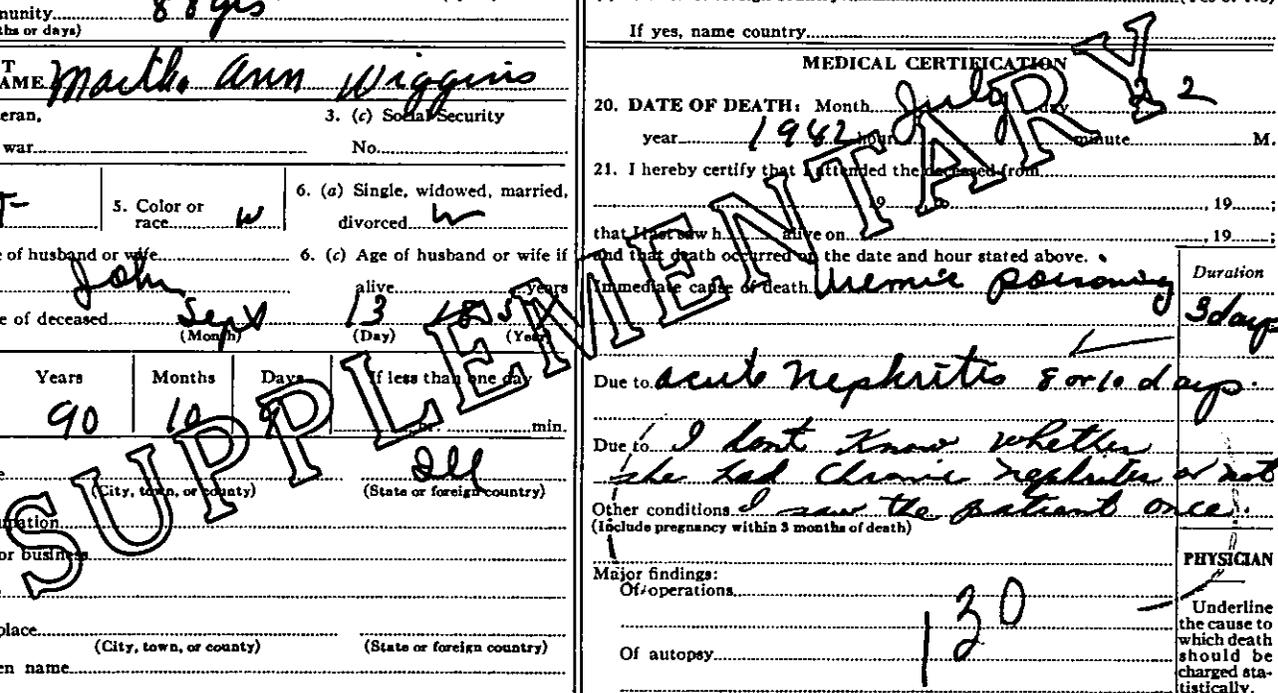
Due to acute nephritis 8 or 10 days
 Due to I dont know whether she had chronic nephritis or not
 Other conditions I saw the patient once
(Include pregnancy within 3 months of death)

PHYSICIAN
 Major findings: _____
 Of operations _____
 Of autopsy _____
 Underline the cause to which death should be charged statistically.
130

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

While at work? _____ (Specify type of place)
 Means of injury _____
 23. Signature A. L. Caldwell M.D. or other D.O.
 Address Shelbina, Mo. Date signed _____

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



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