

S. No. 2
A-9.4.41
5-17-38
P1 X2

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **4925**
Registrar's No. **1612**

FILED MAR 2 1943

Registration District No. **318**

Primary Registration District No. **1003**

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

1. PLACE OF DEATH:

(a) County.....

(b) City or town..... **ST. LOUIS**

(c) Name of hospital or institution:
(If outside city or town limits, write "RURAL" and name of township)
MISSOURI PACIFIC HOSPITAL
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution..... **11 DAYS**
(Specify whether years, months or days)

In this community..... **11 DAYS**

3. (a) PRINT FULL NAME **CHARLES RAYBURN WIGGINS**

3. (b) If veteran, name war.....

3. (c) Social Security No.....

4. Sex **MALE** 5. Color or race **WHITE**

6. (a) Single, widowed, married, divorced, **MARRIED**

6. (b) Name of husband or wife **CORA WIGGINS**

6. (c) Age of husband or wife if alive..... **55** years

7. Birth date of deceased..... **APRIL 24 1874**
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day

68	9	25	hr. min.
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9. Birthplace **DECATUR ALABAMA**
(City, town, or county) (State or foreign country)

10. Usual occupation **RAILROAD CROSSING WATCHMAN**

11. Industry or business **RAILROAD - MO. PAC.**

MOTHER FATHER

12. Name..... **UNKNOWN**

13. Birthplace..... **UNKNOWN U.S.A.**
(City, town, or county) (State or foreign country)

14. Maiden name..... **UNKNOWN**

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

16. (a) Informant **MRS. CORA WIGGINS**

(b) Address **1335 LEXINGTON ST. POPLAR BLUFF MO**

17. (a) **Burial** (Burial, cremation, or removal)

(b) Date thereof..... **FEB 20 1943**
(Month) (Day) (Year)

(c) Place: burial or cremation..... **POPLAR BLUFF MO.**

18. (a) Signature of funeral director **BEIDERWIEDEN Fu. Home, Inc**

(b) Address **1936 S. LOUIS AVE**

19. (a) **FEB 18 1943** (Date received local registrar)

J. F. Broad (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State..... **MISSOURI** (b) County..... **12**

(c) City or town..... **POPLAR BLUFF 3 NR**
(If outside city or town limits, write "RURAL")

(d) Street No. **1335 LEXINGTON ST.**
(If rural, give location)

(e) Citizen of foreign country? **No** (Yes or No)

If yes, name country..... **1**

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Feb** day **18** year **1943** hour **4** minute **50 A.** M.

21. I hereby certify that I attended the deceased from **Feb 7** 19**43** to **Feb 18** 19**43**

that I last saw him alive on **Feb 18** 19**43** and that death occurred on the date and hour stated above.

Immediate cause of death..... **Arteriosclerosis Heart Disease**

Due to..... **Heart block**

Other conditions..... **93**
(Include pregnancy within 3 months of death)

Major findings:
Of operations.....

Of autopsy.....

PHYSICIAN.....

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 **Gilbert Wright** (M. D. ~~.....~~)

Address **1755 S. Grand** Date signed **2-18-43**

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 Theo H. Berderuse den

Licensed Embalmer No. 504

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, fact should be so stated above.