

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **10654**

FILED MAR 19 1943 170

Registration District No. **170**

Primary Registration District No. **3033**

Registrar's No. _____

1. PLACE OF DEATH:

(a) County **LACLEDE**
 (b) City or town **LEBANON**
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
PEARL ST. 1
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution **NEITHER**
 (Specify whether)
 In this community **ALWAYS**
 years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **MO** (b) County **LACLEDE 53**
 (c) City or town **LEBANON**
 (If outside city or town limits, write "RURAL") **2**
 (d) Street No. **PEARL ST**
 (If rural, give location)
 (e) Citizen of foreign country? **No** (Yes or No)
 If yes, name country **0**

3. (a) PRINT FULL NAME **FRITZ HUCH BIGGS**

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

4. Sex **M** 5. Color or face **W** 6. (a) Single, widowed, married, divorced **WIDOW**
 6. (b) Name of husband or wife **IDA HART** 6. (c) Age of husband or wife if alive _____ years
 7. Birth date of deceased **Aug 2 1871**
 (Month) (Day) (Year)

8. AGE: Years **71** Months **6** Days **4** If less than one day hr. min.

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

10. Usual occupation **PAINTER**

11. Industry or business _____
 12. Name **John P Biggs**
 13. Birthplace **TENN**
 (City, town, or county) (State or foreign country)
 14. Maiden name **SARAH IVEY**
 15. Birthplace **MO**
 (City, town, or county) (State or foreign country)

16. (a) Informant **H. J. Biggs**
 (b) Address **LEBANON MO**

17. (a) **BURIAL** (b) Date thereof **2-8-43**
 (Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation **LEBANON**

18. (a) Signature of funeral director **PALMERS**
 (b) Address **LEBANON MO**

19. (a) **2-9-43** (b) **Ernest Roper**
 (Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **FEB** day **6**
 year **1943** hour **5** minute **35 P.M.**

21. I hereby certify that I attended the deceased from **2-2-43** to **2-6-43**
 that I last saw him alive on **2-6-43**
 and that death occurred on the date and hour stated above.

Immediate cause of death **asthma** (7)

Due to _____
 Due to _____
 Other conditions (include pregnancy within 3 months of death) **112**

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 **B. E. Hanell** (M. D. or other) **MD**
 Address **Lebanon Mo** Date signed **2-8-43**

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

MOTHER FATHER

1090

RECEIVED

District Health Officer No. Lacade County Health Unit
District File Number 2-43-21
Date Filed 3-16-43

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 W. W. Babner

Licensed Embalmer No. 1161

P. O. Address Lebanon 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.