

No. 2
1-2-43
5-17-39
X35697

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED DEC 18 1944

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **41583**
Registrar's No. **116**

Registration District No. **200**
Primary Registration District No. **5-725-3041**

1. PLACE OF DEATH:
(a) County **Macon**
(b) City or town **Hudson Macon**
(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 **1** (Specify whether)

In this community _____ years, months or days (Specify whether)
3. (a) PRINT FULL NAME **Barton 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** **Widowed**
6. (b) Name of husband or wife _____ **6. (c) Age of husband or wife if** _____
7. Birth date of deceased: **Nov 28 - 1885**
(Month) (Day) (Year)

8. AGE: Years **88** Months **11** Days **20**
If less than one day _____ hr. _____ min.

9. Birthplace **Bloomington Mo**
(City, town, or county) (State or foreign country)
10. Usual occupation **Retired Farmer**

11. Industry or business
12. Name **Wm Wiggins**
13. Birthplace **Ind**
(City, town, or county) (State or foreign country)
14. Maiden name **Seaman**
15. Birthplace **Mo**
(City, town, or county) (State or foreign country)

16. (a) Informant **Walter Wiggins**
(b) Address **Macon Mo**
17. (a) Cause of death **Myocardial infarction** **(b) Date thereof** **Nov 20 - 44**
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation **Liberty Cem**

18. (a) Signature of funeral director **Robert S. ...**
(b) Address **Macon Mo**
19. (a) Date received local registrar **10/2/44** **(b) Registrar's signature** **Thos B. ...**
(Date received local registrar) (Registrar's signature)

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

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month **Nov** day **18**
year **1944** hour **6** minute **7** M.
21. I hereby certify that I attended the deceased from **Nov 15**
1944 to **Nov 18** **1944**
that I last saw him alive on **Nov 18** **1944**
and that death occurred on the date and hour stated above.

Immediate cause of death **Myocardial with decoup.**
Duration **Sharp.**

Due to _____
Due to _____
Other conditions **Enlarged prostate with retention** ?
(Include pregnancy within 3 months of death)

Major findings:
Of operations _____
Of autopsy **932**
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)
(c) Means of injury **5**
23. Signature **Howard Miller** (M. D. or other)
Address **Macon Mo** Date signed **11-7-44**

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

RECEIVED

District Health Officer No. 10

District File Number *12-44-2029*

Date Filed *DEC 14 1944*

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.....

Albert Skinner

Licensed Embalmer No.....

75-1

P. O. Address.....

Macon Miss

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.