DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED APR 6 1945

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

9376

State File No. 9376

Registration District No. 39 — Primary Registration District No. 4097 — Registrar's No. 47

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

1. PLACE OF DEATH:
(a) County: Cass
(b) City or town: Harrisonville
(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 years, months or days)
In this community: 30 years

2. USUAL RESIDENCE OF DECEASED:
(a) State: Mo (b) County: Cass 19
(c) City or town: Harrisonville 1
(If outside city or town limits, write "RURAL")
(d) Street No.: 0
(If rural, give location)
(e) Citizen of foreign country? 0 (Yes or No)
If yes, name country:

3. (a) PRINT FULL NAME: Eliza B Biggs
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: widow
6. (b) Name of husband or wife: Sanford W Biggs
6. (c) Age of husband or wife if alive: ✓ years
7. Birth date of deceased: August (Month) 12 (Day) 1864 (Year)

8. AGE:

Years	Months	Days	If less than one day
80	6	15	hr. min.

9. Birthplace: Illinois (City, town, or county) / (State or foreign country)
10. Usual occupation: Home Maker
11. Industry or business:
FATHER
12. Name: John Ruler
13. Birthplace: Unknown (City, town, or county) (State or foreign country)
MOTHER
14. Maiden name: Martha Shepherd
15. Birthplace: Unknown (City, town, or county) (State or foreign country)
16. (a) Informant: C. H. Alex
(b) Address: 1119 Campus Rd Lawrence Ks
17. (a) Burial: Burial (Burial, cremation, removal)
(b) Date thereof: Mar 27-45 (Month) (Day) (Year)
(c) Place: burial or cremation: Crescent
18. (a) Signature of funeral director: RUNNENBURGER'S
(b) Address: HARRISONVILLE MO
19. (a) March 27, 1945 (Date received local registrar) (b) Margaret Vella (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 27 year 1945 hour 12 minute 10 A. M.
21. I hereby certify that I attended the deceased from March 25, 1943, to March 27, 1945 that I last saw her alive on March 26, 1945 and that death occurred on the date and hour stated above.

Immediate cause of death: Uraemia Coma — Duration
Due to: Nephritis and Heart disease
Due to:
Other conditions (Include pregnancy within 3 months of death):
Major findings: Of operations: ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED
Of autopsy:

J H Scott M.D.
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? (Specify type of place)
While at work?
(e) Means of injury: 0

23. Signature: J H Scott (M. D. or other)
Address: Harrisonville Mo Date signed: March 29 1945

(Licensed Embalmer's Statement on Reverse Side)

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 Ernest Rennenburger

Licensed Embalmer No. 3368

P. O. Address Harrisonville Ill.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply wit the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.

No. 2B
—5-43
I X36930

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. April

Registration District No. 59 Primary Registration District No. 4097 Registrar's No. 47

1. PLACE OF DEATH:

(a) County Cass

(b) City or town Harrisonville
(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 years, months or days)

In this community

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

3. (a) PRINT FULL NAME Elya B. Biggs

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 M

6. (b) Name of husband or wife

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

7. Birth date of deceased Sept 12 1876
(Month) (Day) (Year)

8. AGE: Years 80 Months 6 Days If less than one day hr. min.

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

10. Usual occupation

11. Industry or business

FATHER
12. Name
13. Birthplace (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name
15. Birthplace (City, town, or county) (State or foreign country)

16. (a) Informant

(b) Address

17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)

(c) Place: burial or cremation

18. (a) Signature of funeral director

(b) Address

19. (a) (Date received local registrar) (b) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March 27 year 1947 hour minute M.

21. I hereby certify that I attended the deceased from , 19 to , 19 ; that I last saw him alive on , 19 ; and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Due to	
Due to Chronic Nephritis	
Other conditions (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? (Specify type of place)

While at work? (e) Means of injury

23. Signature J M Scott (M. D. or other)

Address Date signed

SUPPLEMENTARY

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

13 16

9376