

Registration District No. 299

Primary Registration District No. 6022-4448

Registrar's No. 22

1. PLACE OF DEATH:

(a) County Ray
(b) City or town Lawson
(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 _____
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Ray
(c) City or town Henrietta
(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 _____

3. (a) PRINT FULL NAME Fred Stigall

3. (b) If veteran, name war No
3. (c) Social Security No. 496-26-2600

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Ida F. Stigall 6. (c) Age of husband or wife if alive 64 years

7. Birth date of deceased June 4, 1880
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>64</u>	<u>10</u>	<u>10</u>	hr. _____ min.

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

10. Usual occupation Farming

11. Industry or business _____

12. Name John Stigall

13. Birthplace Tenn.
(City, town, or county) (State or foreign country)

14. Maiden name Sophia Crews
Lafayette Co. Mo.

15. Birthplace _____
(City, town, or county) (State or foreign country)

16. (a) Informant Milferd Stigall

(b) Address Boonville, Mo.

17. (a) Burial (b) Date thereof April 17, 1945
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Richmond Mo.

18. (a) Signature of funeral director J. J. [Signature]
(b) Address Richmond, Mo.

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

MOTHER FATHER

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 14
year 1945 hour 1 minute _____ P. _____ M.

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

Immediate cause of death Coronary Occlusion Duration _____
Death Sudden

Due to _____

Due to _____

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 April 14, 1945

(c) Where did injury occur? Lawson, Ray Mo
(City or town) (County) (State)

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

While at work? yes (Specify type of place) (e) Means of injury 3

23. Signature J. J. Baber Coroner, Ray Co
(City or town) (County) (State)

Address Richmond Mo Date signed 4.16.45

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

1143

RECEIVED

District Health Officer No. 8,

District File Number

Date Filed

5/12/42

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, ~~###~~

Registered Apprentice No.

working under my personal supervision.

Signed

Licensed Embalmer No. 2073

P. O. Address. Richmond . 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.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. May
Registrar's No. 228

Registration District No. 298

Primary Registration District No. 4848

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

1. PLACE OF DEATH:

(a) County Ray

(b) City or town Lansson
(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 _____ (Specify whether _____)
years, months or days

3. (a) PRINT FULL NAME Fred Stigall

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

4. Sex M

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 June (Month) 4 (Day) 1914 (Year)

8. AGE: Years 64 Months _____ Days _____ If less than one day _____ hr. _____ min.

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

10. Usual occupation _____

11. Industry or business _____

MOTHER: { 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) _____ (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) 1/5/19-45 (b) W. Black
(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 April 1945 year, 14 hour, _____ minute M.

21. I hereby certify that I attended the deceased from _____ 19____; that I last saw him _____ alive on _____ 19____; and that death occurred on the date and hour stated above. _____ immediate cause of death.

Due to _____

Due to _____

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

Major findings: _____

Of operations _____

Of autopsy _____

Duration _____

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 _____

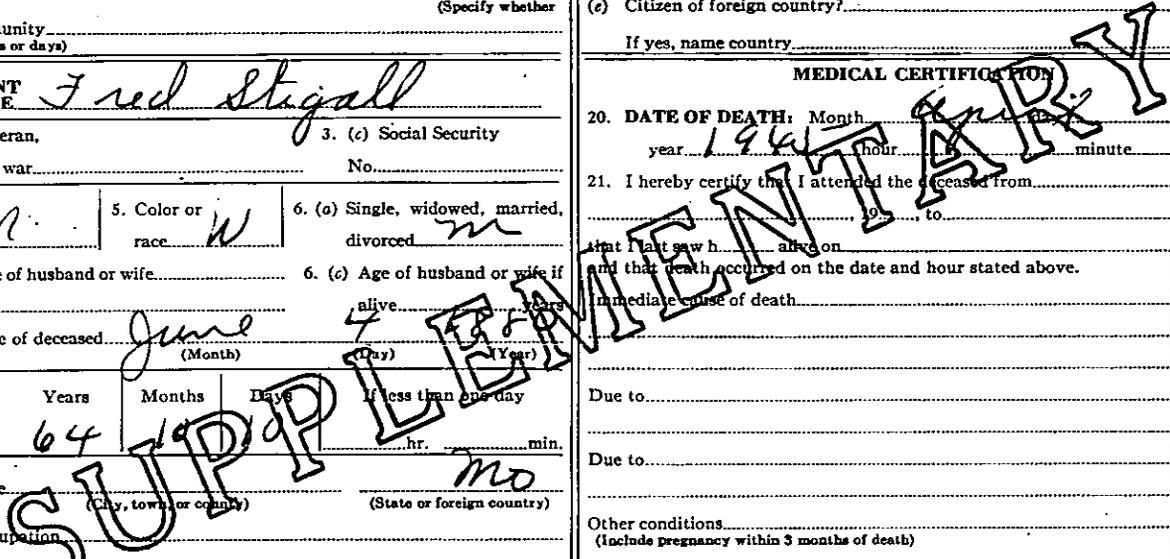
(c) Where did injury occur? _____ (City or town) _____ (County) _____ (State)

(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 _____ (M. D. or other) _____

Address _____ Date signed _____



14402