

Registration District No. **362** Primary Registration District No. **4-5376.234** Registrar's No. **37**

1. PLACE OF DEATH:
(a) County Warren
(b) City or town Rural Clark Union Mo
(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

3. (a) PRINT FULL NAME Mrs E. J. Liggitt
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 Widowed
6. (b) Name of husband or wife _____ **6. (c) Age of husband or wife if alive** _____ years
7. Birth date of deceased Sept 16 1886
(Month) (Day) (Year)

8. AGE: Years 59 Months 3 Days 9 If less than one day _____ hr. _____ min.

9. Birthplace Haward County Mo. 11
(City, town, or county) (State or foreign country)

10. Usual occupation House wife

11. Industry or business _____

12. Name John Tuggle
13. Birthplace Haward County Mo 0
(City, town, or county) (State or foreign country)

14. Maiden name Sargena
15. Birthplace Haward County Mo 0
(City, town, or county) (State or foreign country)

16. (a) Informant J. E. More Jr.
(b) Address 1019 Wall Benton St. Clark Mo.

17. (a) Removal **(b) Date thereof** 12 24 45
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Fayette Mo

18. (a) Signature of funeral director G. A. Harberg
(b) Address Junction, Mo.

19. (a) Dec 26, 1945 **(b) Mrs Hugo Luttmann**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo (b) County Boone 10
(c) City or town Clamonia 2
(If outside city or town limits, write "RURAL") 4
(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 Dec day 23
year 1945 hour 3:30 minute _____ P. M.
21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;
that I last saw h. _____ alive on _____, 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death Fracture of skull and tearing of jaw
Due to accident by trunk of truck while working in passenger car
Due on A. S. H. 40 in Warren Co. Mo

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

Major findings: Of operations _____
Of autopsy _____

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) Accident
(b) Date of occurrence Dec 23 - 1945 10 1

(c) Where did injury occur? Highway 40 Warren Mo
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?
Public highway
While at work? _____ (Specify type of place) (e) Means of injury _____

23. Signature Dr. F. J. King (M. D. or other) _____
Address Warrens Mo Date signed Dec 23 1945

MOTHER FATHER

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

RECEIVED
District Health Officer No. 8,
District File Number.....
Date Filed 1-4-46

JAN 16 1946

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 Carl A. Harding
Licensed Embalmer No. 4115
P. O. Address Convalburg, Mo

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

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

Registration District No. 362

Primary Registration District No. 6234

1. PLACE OF DEATH:

(a) County Warren
(b) City or town Rural Elk Horn Twp
(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)

3. (a) PRINT FULL NAME Viola Liggett

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 wid

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____

7. Birth date of deceased Sept 14 1888
(Month) (Day) (Year)

8. AGE: Years 59 Months 3 Days _____ (Unless than one day)
hr. _____ min.

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

10. Usual occupation _____

11. Industry or business _____

12. Name _____

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

14. Maiden name _____ (City, town, or county) (State or foreign country)

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

16. (a) Informant _____ (b) Address _____

17. (a) _____ (b) Date thereof _____ (Month) (Day) (Year)
(Burial, cremation, or removal) (c) Place: burial or cremation _____

13. (a) Signature of funeral director _____ (b) Address _____

19. (a) _____ (b) _____ (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 _____ Year 1945 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ to _____ that I last saw him _____ alive on _____ 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 _____

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 _____

SUPPLEMENTARY

Duration _____
PHYSICIAN _____
Underline the cause to which death should be charged statistically.

WHILE I PRINTED - USE UNFADING BLACK INK - MAKE A FURNITURE

