

STANDARD CERTIFICATE OF DEATH

State File No. **4310**Registration District No. **335**Primary Registration District No. **6-2-0-2 4520**

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Texas
 (b) City or town Summersville Missouri
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution: None
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution No
 (Specify whether
 In this community 5 Years
 years, months or days)

3. (a) PRINT FULL NAME Edgar S. Igon3. (b) If veteran? name war No 3. (c) Social Security No. No4. Sex Male 5. Color or race W 6. (a) Single, widowed, married, divorced Married6. (b) Name of husband or wife Susie Igon 6. (c) Age of husband or wife if alive 63 years7. Birth date of deceased February 25th 1878
(Month) (Day) (Year)8. AGE: Years 71 Months 11 Days _____ If less than one day
hr. _____ min.9. Birthplace Illinois
(City, town, or county) (State or foreign country)10. Usual occupation Farming

11. Industry or business _____

12. Name Harrison Igon13. Birthplace Indiana
(City, town, or county) (State or foreign country)14. Maiden name Not Known15. Birthplace Not Known
(City, town, or county) (State or foreign country)16. (a) Informant Nelson Igon(b) Address Summersville17. (a) Burial (b) Date thereof Jan 27, 46
(Burial, cremation, or removal) (Month) (Day) (Year)(c) Place: burial or cremation Summersville, Mo18. (a) Signature of funeral director John L. Amman(b) Address Mountain View, Mo19. (a) 1-30-1946 (b) Mrs C. E. Murfin
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Texas **107**
 (c) City or town Summersville Mo **0**
 (If outside city or town limits, write "RURAL")
 (d) Street No. Rural **0**
 (If rural, give location)
 (e) Citizen of foreign country? No (Yes or No) **1**
 If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan, day 25th
year 1946 hour 1 minute 30 a.m.21. I hereby certify that I attended the deceased from Oct 1945 to JAN 25 1946
that I last saw him alive on JAN 24 1946
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Hemorrhage Duration _____
 Due to arterial hypertension
 Due to asthma & 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?

While at work? _____ (Specify type of place)
(or) Means of injury _____23. Signature Dr. Lawrence H. Smith (M. D. or other) **D.O.**
Address Summersville Date signed Jan 27

(Licensed Embalmer's Statement on Reverse Side)

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

2
43
39
35697

326

APR 16 1948

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.....

working under my personal supervision.

Registered Apprentice No.....

Signed.....

John F. Shuman

Licensed Embalmer No.....

2516-C

P. O. Address.....

North View M

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.

2B
3-45
X43880

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. *zet*

Registration District No. *355*

Primary Registration District No. *4520*

Registrar's No.

1. PLACE OF DEATH:

(a) County *Texas*
(b) City or town *Summersville*
(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 *Edgar S. Igon*
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 *in*
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased *zet. 25* (Month) (Day) (Year)

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

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

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER { 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) _____ (b) Date thereof _____ (Month) (Day) (Year)
(Burial, cremation, or removal)

(c) Place: burial or cremation _____

18. (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 _____ Day _____
year *1946* hour _____ minute _____ M.

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

Chronic Infection
Due to _____

Due to _____

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

Major findings: Of operations _____

Of autopsy *B/W*

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 _____

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

SUPPLEMENTARY

3385

APR 16 1945

4310