

Registration District No. 187

Primary Registration District No. 3040

Registrar's No. 152

1. PLACE OF DEATH:

(a) County Linn

(b) City or town Chillicothe
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: Chillicothe Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 12 hours
(Specify whether)

In this community _____
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State MO

(b) County Linn

(c) City or town Hale
(If outside city or town limits, write "RURAL")

(d) Street No. Rural
(If rural, give location)

(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME TERRY GALE FIGG

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 0

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

7. Birth date of deceased December 17 1946
(Month) (Day) (Year)

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec day 18 year 1946 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from Dec 17 1946, to Dec 18 1946, that I last saw him alive on Dec 17 1946 and that death occurred on the date and hour stated above.

Immediate cause of death Twin birth prematurity

Due to _____

Due to _____

Other conditions 159
(Include pregnancy within 3 months of death)

Major findings: Of operations _____

Of autopsy _____

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

MOTHER FATHER

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

10. Usual occupation _____

11. Industry or business _____

12. Name Ralph Figg

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

14. Maiden name Martha Fitzpatrick

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

16. (a) Informant Ralph Figg

(b) Address Hale Missouri

17. (a) Burial (b) Date thereof Dec 18 1946
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Hale cemetery

18. (a) Signature of funeral director Frank G. Staley

(b) Address Hale Missouri

19. (a) Dec-17-46 (b) Frances B. Neill
(Date received local registrar) (Registrar's signature)

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 J. M. Dawell (M. D. or other) _____
Address Chillicothe Date signed 12/12/46

DISTRICT HEALTH OFFICE
Cameron, Mo.

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was ^{not} embalmed by me, or by.....
....., Registered Apprentice No.....
working under my personal supervision.

Signed Henry E. Slater
Licensed Embalmer No. 937
P. O. Address Hole Me

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to complete 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. Jan
Registrar's No. 152

Registration District No. 187 Primary Registration District No. 3040

1. PLACE OF DEATH:

(a) County Livingston
(b) City or town Chillicothe
(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

Jerry G. Figg

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 _____

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

7. Birth date of deceased Dec 17 1946
(Month) (Day) (Year)

8. AGE: Years 0 Months 0 Days 2 If less than one day _____ hr. 3 min. _____

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

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) _____ (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) Dec-17-46 (Date received local registrar) (b) Frances B. Neill (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Livingston
(c) City or town Hale Russell
(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 Dec Day 18 Year 1946 Hour _____ minute _____ M.

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

Duration

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 _____

(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

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE PERMANENT RECORD

41254