No. 2
—1/47
5-17-39

FEDERAL SECURITY AGENCY
National Office of Vital Statistics
FILED MAR 17 1948

MISSOURI DIVISION OF HEALTH
# STANDARD CERTIFICATE OF DEATH

9921

State File No.

Registration District No. 316 Primary Registration District No. 6071 Registrar's No. 70

1. PLACE OF DEATH:
(a) County St. Francois
(b) City or town Rural Marion Town Ship
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Bonne Terre Route one, Mo
(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 Mo. (b) County St. Francois
(c) City or town Rural - Marion Township 74
(If outside city or town limits, write "RURAL")
(d) Street No. Bonne Terre Rural Route One 0
(If rural, give location)
(e) Citizen of foreign country? No. (Yes or No) 0
If yes, name country 0

3. (a) PRINT FULL NAME Harold Edward Sigman
3. (b) If veteran, name war world war 1
3. (c) Social Security No. unknown
4. Sex Male 0
5. Color or race white
6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife May Sigman
6. (c) Age of husband or wife if alive 48 years
7. Birth date of deceased September 28, 1895 (Month) (Day) (Year)

8. AGE:

| Years | Months | Days | If less than one day |
|---|---|---|---|
| 52 | 5 | 4 | hr. min. |

9. Birthplace Doe Run (City, town, or county) Mo. (State or foreign country) 0
10. Usual occupation Farmer
11. Industry or business Self
FATHER
12. Name Frank Sigman
13. Birthplace (City, town, or county) North Carolina (State or foreign country)
MOTHER
14. Maiden name Martha Jhonson
15. Birthplace (City, town, or county) Illinois (State or foreign country)
16. (a) Informant Mrs. May Sigman
(b) Address Bonne Terre, Route One Mo
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-4-48 (Month) (Day) (Year)
(c) Place: burial or cremation Marvin Chapel
18. (a) Signature of funeral director C. Z. Boyer & Son
(b) Address Desloge, Mo.
19. (a) 3-6-48 (Date received local registrar) (b) Esther Rudloff (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 2
year 1948 hour 8 minute 0 a.M.
21. I hereby certify that I attended the deceased from Aug 27 1947 to March 2 1948
that I last saw him alive on Feb 27 1948
and that death occurred on the date and hour stated above.

| | Duration |
|---|---|
| Immediate cause of death Chr. myocarditis | |
| Chr. nephritis | |
| Due to | |
| Due to | |
| Other conditions (Include pregnancy within 3 months of death) | |
| Major findings: Of operations | |
| Of autopsy 131 B | |

PHYSICIAN
Underline the cause of 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 C H Applebery (M. D. or other) M.D
Address Flat River MO Date signed 2.4.48

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

Jefferson City Printing Co. (Licensed Embalmer's Statement on Reverse Side)

RECEIVED

District Health Officer No. 4

District File Number 348-357

Date Filed 3-16-48

JUN 24 1946

APR 2 1948

MAR 29 1948

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**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 C. L. Boyer

Licensed Embalmer No. 1671

P. O. Address Desloge 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.**