

FILED JUL 10 1948

Registration District No. 258

Primary Registration District No. 4390

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

1. PLACE OF DEATH:

(a) County Osage  
(b) City or town Metz, Mo.  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: 1  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 83 years (Specify whether years, months or days)  
In this community 83 years

3. (a) PRINT FULL NAME MARGARET HERIGON

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 married  
6. (b) Name of husband or wife Simon Herigon 6. (c) Age of husband or wife if alive 83 years  
7. Birth date of deceased February 9 1865  
(Month) (Day) (Year)

8. AGE: Years 83 Months 4 Days 23 If less than one day hr. min. 0

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

10. Usual occupation Housewife

11. Industry or business

MOTHER FATHER {  
12. Name Theodore Herp 4  
13. Birthplace Germany 4  
(City, town, or county) (State or foreign country)  
14. Maiden name Catherine Docks  
15. Birthplace Germany 4  
(City, town, or county) (State or foreign country)

16. (a) Informant Theodore Herigon  
(b) Address St. Thomas St. Mo.

17. (a) Burial (b) Date thereof July 5 1948  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation St. Thomas Cemetery

18. (a) Signature of funeral director H. H. Strop  
(b) Address Metz Mo

19. (a) 7-348 (b) Rose Rowden  
(Date received local registrar) (Registrar's signature) 7. 24 48

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Cole 26  
(c) City or town St. Thomas 0  
(If outside city or town limits, write "RURAL")  
(d) Street No. 1  
(If rural, give location)  
(e) Citizen of foreign country? no (Yes or No)  
If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 2  
year 1948 hour 3 minute 15 P.M.

21. I hereby certify that I attended the deceased from — 19— to — 1948  
that I last saw her alive on Wed. 30 1948  
and that death occurred on the date and hour stated above.

Immediate cause of death Arterial Heart Disease

Due to Overcompensation  
hypertension  
Due to Abdominal Tumor,  
Type Unknown.

Other conditions (Include pregnancy within 3 months of death)

Major findings: 57K  
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 2

23. Signature D. S. W. Easton (M.D. or other) D.O.  
Address Metz, Mo. Date signed July 24

**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, *H H Sharp*

Licensed Embalmer No. *2924*

P. O. Address. *Meta 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. July  
Registrar's No. 6 J

Registration District No. 258

Primary Registration District No. 4390

**1. PLACE OF DEATH:**

(a) County Osage

(b) City or town meta  
(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** Margaret Kriger

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 M

6. (b) Name of husband or wife \_\_\_\_\_

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

7. Birth date of deceased Feb 9  
(Month) (Day) (Year)

**8. AGE:** Years 83 Months 4 Days 1  
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 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 \_\_\_\_\_  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_

(b) Address \_\_\_\_\_

19. (a) 7-3-48 (b) Rose Rowan  
(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 1948 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_ to \_\_\_\_\_, 19\_\_\_\_; that I last saw him/her \_\_\_\_\_, 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)

**PHYSICIAN**

Major findings:  
Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

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 2

S-20278

5