

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. _____

SEP 26 1949

BIRTH NO. _____ REG. DIST. NO. 155 PRIMARY REG. DIST. NO. 3127- Registrar's No. 158

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

1. PLACE OF DEATH a. COUNTY Jasper		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Jasper	
b. CITY (If outside corporate limits, write RURAL and give township) Webb City		c. CITY (If outside corporate limits, write RURAL and give township) Joplin	
c. LENGTH OF STAY (In this place) 2 days		d. STREET ADDRESS (If rural, give location) 1201 Kentucky Ave.	
d. FULL NAME OF HOSPITAL OR INSTITUTION Jane Chin Hospital			

3. NAME OF DECEASED (Type or Print)	a. (First) Isaac	b. (Middle) Elbert	c. (Last) Biggs	4. DATE OF DEATH (Month) (Day) (Year)	9	10	49
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5. SEX M	6. COLOR OR RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) widowed	8. DATE OF BIRTH 9-25-1876	9. AGE (In years last birthday) 72	IF UNDER 1 YEAR (Month) (Day) (Hour) (Min.) 11 16	IF UNDER 24 HRS. (Hour) (Min.)
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Minister	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Missouri	12. CITIZEN OF WHAT COUNTRY USA.
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13a. FATHER'S NAME David S. Biggs	13b. MOTHER'S MAIDEN NAME Mellissa Trim	14. NAME OF HUSBAND OR WIFE deceased
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no	16. SOCIAL SECURITY NO. x	17. INFORMANT'S SIGNATURE OR NAME Mrs Julia Reynolds	ADDRESS Joplin Mo.
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Pulmonary Hemorrhage		2 days
	ANTECEDENT CAUSES Morbid conditions; if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Cancer of Lung Right DUE TO (c) Infection & Embolus		6 months
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			163X

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
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22. I hereby certify that I attended the deceased from 9-8, 1949, to 9-10, 1949, that I last saw the deceased alive on 9-10, 1949, and that death occurred at 3:25 p.m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) J. J. Del	23b. ADDRESS Joplin Mo.	23c. DATE SIGNED 9-12-49
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24a. BURIAL, CREMATION, REMOVAL (Specify) burial	24b. DATE 9-12-49	24c. NAME OF CEMETERY OR CREMATORY Fairview Cemetery	24d. LOCATION (City, town, or county) Joplin Mo.
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DATE REC'D BY LOCAL REG. SEPT. 12, 1949	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR'S SIGNATURE	ADDRESS 887. Galena Kansas
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(Licensed Embalmer's Statement on Reverse Side)

RECEIVED 9-19-49
Jasper County Health Office

County File Number 49-9-714

Date Filed 9-24-49

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~~ _____

Student Embalmer No. _____

working under my personal supervision.

Signed Howard E. Gibson

Signed _____
Student Embalmer

KANSAS Licensed Embalmer No. 2310

P. O. Address Galena, Kans.

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.