0.300
0.48

72

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

# THE DIVISION OF HEALTH OF MISSOURI
# STANDARD CERTIFICATE OF DEATH

State File No. 4432

FILED JAN 26 1953 BIRTH NO. REG. DIST. NO. 324 PRIMARY REG. DIST. NO. 3072 Registrar's No. 17

**1. PLACE OF DEATH**
a. COUNTY: Saline
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Marshall
c. LENGTH OF STAY (in this place): 3 yrs.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 162½ S. Jefferson

**2. USUAL RESIDENCE** (Where deceased lived. If institution: residence before admission).
a. STATE: Missouri
b. COUNTY: Saline
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Marshall 0972
d. STREET ADDRESS (If rural, give location): 162½ S. Jefferson 0

**3. NAME OF DECEASED** (Type or Print)
a. (First): WILLIAM
b. (Middle): VERTS
c. (Last): FIGGINS

**4. DATE OF DEATH** (Month) (Day) (Year): Jan. 19, 1953

**5. SEX**: Male 0
**6. COLOR OR RACE**: White
**7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED** (Specify): Widowed 2
**8. DATE OF BIRTH**: Jan. 24, 1872
**9. AGE** (In years last birthday): 80
IF UNDER 1 YEAR: Months — Days —
IF UNDER 24 HRS.: Hours — Min. —

**10a. USUAL OCCUPATION** (Give kind of work done during most of working life, even if retired): Tenant Farmer
**10b. KIND OF BUSINESS OR INDUSTRY**: Farm
**11. BIRTHPLACE** (State or foreign country): Missouri 0
**12. CITIZEN OF WHAT COUNTRY?**: U.S.A.

**13a. FATHER'S NAME**: Joseph Figgins
**13b. MOTHER'S MAIDEN NAME**: Margaret West
**14. NAME OF HUSBAND OR WIFE**: ------- -------

**15. WAS DECEASED EVER IN U.S. ARMED FORCES?** (Yes, no, or unknown): No
(If yes, give war or dates of service): ----------
**16. SOCIAL SECURITY NO.**: None
**17. INFORMANT'S SIGNATURE OR NAME**: Mrs. A. N. Dickson
ADDRESS: Arrow Rock, Mo

**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, asthenia, etc. It means the disease, injury, or complication which caused death.*

**MEDICAL CERTIFICATION**

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Pneumonia (Lung) — INTERVAL BETWEEN ONSET AND DEATH: 2 days

ANTECEDENT CAUSES

*Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.*

DUE TO (b) ____ — INTERVAL: ____

DUE TO (c) Arteriosclerosis — INTERVAL: 2 yrs.

II. OTHER SIGNIFICANT CONDITIONS

*Conditions contributing to the death but not related to the disease or condition causing death.*

**19a. DATE OF OPERATION**
**19b. MAJOR FINDINGS OF OPERATION**: 492X
**20. AUTOPSY?** YES ☐ NO ☑

**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)

**21d. TIME OF INJURY** (Month) (Day) (Year) (Hour) m.
**21e. INJURY OCCURRED** WHILE AT WORK ☐ NOT WHILE AT WORK ☐
**21f. HOW DID INJURY OCCUR?**

22. *I hereby certify that I attended the deceased from* 1/15, 1953, *to* 1/19, 1953, *that I last saw the deceased alive on* 1-19, 19____, *and that death occurred at* 2:15P *m., from the causes and on the date stated above.*

**23a. SIGNATURE** [signature] 0 (Degree or title): M.D.
**23b. ADDRESS**: Marshall, Mo.
**23c. DATE SIGNED**: 1-20-53

**24a. BURIAL, CREMATION, REMOVAL** (Specify): Burial
**24b. DATE**: 1-21-1953
**24c. NAME OF CEMETERY OR CREMATORY**: Arrow Rock Cem.
**24d. LOCATION** (City, town, or county) (State): Arrow Rock, Mo.

DATE REC'D BY LOCAL REG.: Jan. 20, 1953
REGISTRAR'S SIGNATURE: Sidney T. Gray 385 0
**25. FUNERAL DIRECTOR'S SIGNATURE**: Harry Hershberger
ADDRESS: Marshall Mo

(Licensed Embalmer's Statement on Reverse Side)

## 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.

Student .....
Student Embalmer

Signed Joseph R. Mackler

Licensed Embalmer No. 4571

P. O. Address Marshall, M

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply w the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.