

FILED SEP 14 1955

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **34440**  
Registrar's No. **586**

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. **301** PRIMARY REG. DIST. NO. **4450**

|  |  |   |   |
|--|--|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Ripley</b>   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>a. STATE <b>Missouri</b> b. COUNTY <b>Ripley</b> |   |
| b. CITY (If outside corporate limits, write RURAL and give township) <b>Doniphan</b> |  | c. CITY OR TOWN <b>Doniphan</b>   | d. Is Residence within limits of a city or incorporated town?<br>Yes <input type="checkbox"/> No <input type="checkbox"/> |
| c. LENGTH OF STAY (in this place) <b>7 Days</b>                                      |  | e. STREET ADDRESS (If rural, give location) <b>Rte. 4</b>   |   |
| d. FULL NAME OF HOSPITAL OR INSTITUTION <b>Community Hosp. Tak.</b>                  |  |   |   |

|                                     |                          |                       |                         |   |
|-------------------------------------|--------------------------|-----------------------|-------------------------|---|
| 3. NAME OF DECEASED (Type or Print) | a. (First) <b>Maggie</b> | b. (Middle) <b>M.</b> | c. (Last) <b>Rigdon</b> | 4. DATE OF DEATH (Month) (Day) (Year) <b>July 8, 1955</b> |
|-------------------------------------|--------------------------|-----------------------|-------------------------|---|

|  |                               |  |                                      |  |  |  |
|--|-------------------------------|--|--------------------------------------|--|--|--|
| 5. SEX <b>Female</b>   | 6. COLOR OR RACE <b>White</b> | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <input checked="" type="checkbox"/> | 8. DATE OF BIRTH <b>Aug 23, 1890</b> | 9. AGE (In years last birthday) <b>64</b>                          | IF UNDER 1 YEAR<br>Months <b>15</b> Days <b>15</b> | IF UNDER 24 HRS.<br>Hours <b>15</b> Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b> |                               | 10b. KIND OF BUSINESS OR INDUSTRY  |                                      | 11. BIRTHPLACE (City and State or Foreign Country) <b>Arkansas</b> |  | 12. CITIZEN OF WHAT COUNTRY? <b>USA</b>  |

|                                     |  |   |
|-------------------------------------|--|---|
| 13a. FATHER'S NAME <b>John Goff</b> | 13b. MOTHER'S MAIDEN NAME <b>MARY GRAHAM</b> | 14. NAME OF HUSBAND OR WIFE <b>Tom Rigdon</b> |
|-------------------------------------|--|---|

|  |                         |   |                              |
|--|-------------------------|---|------------------------------|
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>NO</b> | 16. SOCIAL SECURITY NO. | 17. INFORMANT'S SIGNATURE OR NAME <b>Alma Coleman</b> | ADDRESS <b>St. Louis, Mo</b> |
|--|-------------------------|---|------------------------------|

|   |  |             |   |
|---|--|-------------|---|
| 18. CAUSE OF DEATH<br>Enter only one cause per line for (a), (b), and (c)<br><br>*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  |             | INTERVAL BETWEEN ONSET AND DEATH<br><b>1 week</b><br><b>3 years</b> |
|   | I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Cerebral hemorrhage</b>  |             |   |
|   | ANTECEDENT CAUSES<br>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.<br>DUE TO (b) <b>arterio-sclerotic heart disease</b><br>DUE TO (c) |             |   |
| II. OTHER SIGNIFICANT CONDITIONS<br>Conditions contributing to the death but not related to the disease or condition causing death.   |  | <b>4200</b> |   |

|                        |                                  |   |
|------------------------|----------------------------------|---|
| 19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
|------------------------|----------------------------------|---|

|  |  |   |
|--|--|---|
| 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 <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | 21f. HOW DID INJURY OCCUR? |
|--|--|----------------------------|

22. I hereby certify that I attended the deceased from **January**, 1955, to **July 8**, 1955, that I last saw the deceased alive on **7-8-55**, 1955, and that death occurred at **7:20 a.m.**, from the causes and on the date stated above.

|  |                                  |                                |
|--|----------------------------------|--------------------------------|
| 23a. SIGNATURE (Degree or title) <b>Frank Johnson M.D.</b> | 23b. ADDRESS <b>Doniphan, Mo</b> | 23c. DATE SIGNED <b>7-8-55</b> |
|--|----------------------------------|--------------------------------|

|   |                          |  |   |
|---|--------------------------|--|---|
| 24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b> | 24b. DATE <b>7-10-55</b> | 24c. NAME OF CEMETERY OR CREMATORY <b>White Church</b> | 24d. LOCATION (City, town, or county) (State) <b>Brinkley, Arkansas</b> |
|---|--------------------------|--|---|

|  |   |  |                               |
|--|---|--|-------------------------------|
| DATE REC'D BY LOCAL REG. <b>9-7-55</b> | REGISTRAR'S SIGNATURE <b>CR Johnson</b> 277 | 25. FUNERAL DIRECTOR'S SIGNATURE <b>Wylie Funeral Home</b> | ADDRESS <b>Brinkley, Ark.</b> |
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

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8961 13 110

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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 ....., Student Embalmer No..... working under my personal supervision..

Student.....  
Signature of Student Embalmer

Signed.....

Licensed Embalmer No.....

P. O. Address.....

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.