V.S. No. 300
Rev. 10.48

FILED OCT 1 - 1956

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

30002
State File No.

BIRTH NO. _____ REG. DIST. NO. 46 PRIMARY REG. DIST. NO. 5156 Registrar's No. 32

1. PLACE OF DEATH
a. COUNTY: Caldwell
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Rural Rockford
c. LENGTH OF STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): X

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Mo
b. COUNTY: Caldwell
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Rural Rockford
d. STREET ADDRESS (If rural, give location): 0130

3. NAME OF DECEASED (Type or Print)
a. (First): Sarah
b. (Middle): Jane
c. (Last): Rigdon

4. DATE OF DEATH (Month) (Day) (Year): Sept 12-1956

5. SEX: Fem
6. COLOR OR RACE: Wh
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed
8. DATE OF BIRTH: Aug. 22. 1873
9. AGE (In years last birthday): 83 | IF UNDER 1 YEAR Months Days: 20 | IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired
10b. KIND OF BUSINESS OR INDUSTRY: Housekeeper
11. BIRTHPLACE (City and State or Foreign Country): Caldwell Co. Mo
12. CITIZEN OF WHAT COUNTRY?

13a. FATHER'S NAME: Samuel Pollard
13b. MOTHER'S MAIDEN NAME: Rebecca Hutchings
14. NAME OF HUSBAND OR WIFE: Buel F. Rigdon (Dec)

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): ✓
16. SOCIAL SECURITY NO.: ✓
17. INFORMANT'S SIGNATURE OR NAME: Mrs Clarence Arnots
ADDRESS: Polo 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): Cerebral Hemorrhage
INTERVAL BETWEEN ONSET AND DEATH: 7 days

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

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: 331X
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* 9/11, 1956, *to* 9/12, 1956, *that I last saw the deceased alive on* 9/11, 1956, *and that death occurred at* _____ *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): J. Kimes M.D.
23b. ADDRESS: Cameron Mo
23c. DATE SIGNED: 9-17-56

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 9-14-1956
24c. NAME OF CEMETERY OR CREMATORY: Prairie Ridge
24d. LOCATION (City, town, or county) (State): Rockford Twp Caldwell Co Mo

DATE REC'D BY LOCAL REG.: Sept 19-56
REGISTRAR'S SIGNATURE: Gladys Jones
25. FUNERAL DIRECTOR'S SIGNATURE: Alspaugh + Cowley
ADDRESS: Polo Mo

(Licensed Embalmer's Statement on Reverse Side)

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

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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 _____
Student Embalmer

Signed Erwin L. Trowbridge

Licensed Embalmer No. 4924

P. O. Address Polo, 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.