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THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

FILED FEB 11 1957

STATE FILE NUMBER 1799

Registration District No. 172 Primary Registration District No. 3034 Registrar's No. 10

1. PLACE OF DEATH a. COUNTY <i>Lafayette</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Mo</i> b. COUNTY <i>Lafayette</i>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <i>Higginsville</i>		c. CITY OR TOWN <i>Higginsville</i>	
c. FULL NAME OF HOSPITAL OR INSTITUTION <i>119E 15TH</i>		d. STREET ADDRESS (If outside, give location) <i>119E 15TH</i>	

3. NAME OF DECEASED (Type or print) <i>EMMA Jane Rigg</i>			4. DATE OF DEATH Month <i>1</i> Day <i>2</i> Year <i>1957</i>		
5. SEX <i>Female</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>11-11-1859</i>	9. AGE (In years last birthday) <i>97</i>	IF UNDER 1 YEAR Months <i>1</i> Days <i>23</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even, if retired) <i>House Wife</i>		10b. KIND OF BUSINESS OR INDUSTRY —	11. BIRTHPLACE (City and state or country) <i>Lafayette Co. Mo</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>
13. FATHER'S NAME <i>James A. Strafer</i>			14. MOTHER'S MAIDEN NAME <i>Mary Ann Wood</i>		
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 <i>C. Hugh Rigg (son) Higginsville Mo</i>		

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral Thrombosis</i>		INTERVAL BETWEEN ONSET AND DEATH <i>72 Hours</i> <i>Years —</i>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <i>Generalized Arterio Sclerosis</i>	
	DUE TO (c) —	

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Chronic Glomerulonephritis</i>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Hour <i>9:00 pm</i> Month <i>March</i> Day <i>25</i> Year <i>1957</i>	20d. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		

20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION <i>Higginsville Mo</i>	COUNTY <i>Lafayette</i>	STATE <i>Mo</i>
21. I attended the deceased from <i>March 1950</i> to <i>Jan 25 57</i> and last saw her alive on <i>Jan 2-57</i> . Death occurred at <i>9:00 pm</i> on the <i>25</i> day stated above; and to the best of my knowledge from the causes stated.				
22a. SIGNATURE (Degree or title) <i>W. Koppensund</i>		22b. ADDRESS <i>Mrs Higginsville Mo</i>		22c. DATE SIGNED <i>Jan 7-57</i>

23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	23b. DATE <i>1-4-1957</i>	23c. NAME OF CEMETERY OR CREMATORY <i>City Cemetery</i>	23d. LOCATION (City, town, or county) (State) <i>Higginsville Mo</i>
24. FUNERAL DIRECTOR <i>W. Koppensund</i>		25. DATE RECD. BY LOCAL REG. <i>Jan 31-1957</i>	26. REGISTRAR'S SIGNATURE <i>Clayton H. Landrum</i>

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes.

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 *Tom L. Thurman*

Licensed Embalmer No. *456*

P. O. Address *Palmer*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING.
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.