

URI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-035884

FILED VS NOV 9 1959

STATE FILE NUMBER

Registration District No. 128 Primary Registration District No. 2000 Registrar's No. 1135 C

RECEIVED

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| 1. PLACE OF DEATH a. COUNTY <u>Green County</u> | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo</u> b. COUNTY <u>Green</u> | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) <u>Springfield, Mo</u> | | c. CITY OR TOWN <u>Springfield, Mo</u> | |
| Length of stay in lb <u>2 Years</u> | | Inside Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> | |
| c. FULL NAME OF DECEASED (If not in hospital, give location) <u>Foster Rest Home</u> | | d. STREET ADDRESS (If outside, give location) <u>Springfield, Mo Rt. I</u> | |
| HOSPITAL OR INSTITUTION <u>Springfield, Mo Rt. I</u> | | Reside on Farm <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> | |

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| 3. NAME OF DECEASED (Type or print) First <u>Charley</u> Middle <u>Rigdon</u> Last <u>Rigdon</u> | | | 4. DATE OF DEATH Month <u>Oct</u> Day <u>22</u> Year <u>1959</u> | | |
| 5. SEX <u>Male</u> | 6. COLOR OR RACE <u>White</u> | 7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH <u>Oct 22/76</u> | 9. AGE (last birthday) <u>83</u> | IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> |

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| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Farmer</u> | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (City and state or country) <u>Green County Mo</u> | 12. CITIZEN OF WHAT COUNTRY <u>U S A</u> |
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| 13a. FATHER'S NAME <u>John Rigdon</u> | 13b. MOTHER'S MAIDEN NAME <u>Nancy Day</u> | 14. NAME OF HUSBAND OR WIFE <u>Nitha Rigdon</u> |
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| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u> | 16. SOCIAL SECURITY NO. | 17. INFORMANT <u>Mrs Nitha Rigdon, Springfield, Mo</u> |
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| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) | | INTERVAL BETWEEN ONSET AND DEATH |
| PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardio - Renal - Vascular Disease</u> | | |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. | DUE TO (b) _____ DUE TO (c) _____ | |

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| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) | | PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown |
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| 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.) |
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| 20c. TIME OF INJURY Hour _____ a.m. _____ p.m. | Month, Day, Year _____ |
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|--|--|------------------------------|--------|-------|
| 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 | COUNTY | STATE |
|--|--|------------------------------|--------|-------|

21. I attended the deceased from 9-25-59 to 10-22-59 and last saw him alive on 10-9-59
Death occurred at 1:15 P.M. m on the date stated above, and to the best of my knowledge, from the causes stated.

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| 22a. SIGNATURE <u>Thas Velt W</u> | (Degree) (Title) | 22b. ADDRESS <u>1715 Booneville Springfield Missouri</u> | 22c. DATE SIGNED <u>10-3-59</u> |
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| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | 23b. DATE <u>10/25/59</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>Highlandville Mo</u> | 23d. LOCATION (City, town, or county) (State) <u>Christian Co. Mo</u> |
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| 24. FUNERAL DIRECTOR <u>T. B. Chaffin</u> | ADDRESS <u>Ozark, Mo.</u> | 25. DATE RECD. BY LOCAL REG. <u>11-6-59</u> | 26. REGISTRAR'S SIGNATURE <u>Effie S. Meeton</u> |
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(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

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 T. B. Chaffin

Licensed Embalmer No. 2192

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