

**IRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH**

**=60-004674**

FILED VS JAN 11 1960

Registration District No. 324 Primary Registration District No. 30720 Registrar's No. 4

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <u>Saline</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo</u> b. COUNTY <u>Saline</u>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Marshall</u>		Length of stay in lb <u>30 hrs.</u>		c. CITY OR TOWN <u>Slater</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Fitzgibbon Hospital</u>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>525 E. Parker</u>			Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Anthony</u> Middle <u>Adam</u> Last <u>Giger</u>				4. DATE OF DEATH Month <u>January</u> Day <u>6</u> Year <u>1960</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>6-20-1891</u>	9. AGE (last birthday) <u>68</u>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HR Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Salesman</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Automobile</u>		11. BIRTHPLACE (City and state or country) <u>Saline County, Mo.</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>
13a. FATHER'S NAME <u>George Giger</u>			13b. MOTHER'S MAIDEN NAME <u>Barbara Englert</u>			14. NAME OF HUSBAND OR WIFE <u>Lucille Giger</u>	
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. <u>486-03-6834</u>		17. INFORMANT Address <u>Mrs. T. A. Giger, Slater, Mo.</u>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Massive Cerebral Hemorrhage</u> DUE TO (b) <u>Generalized arteriosclerosis</u> DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.							INTERVAL BETWEEN ONSET AND DEATH <u>28 hrs</u> <u>20 yrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Severe (B) bronchial asthma (C) Pulmonary Emphysema</u> <u>arteriosclerosis, heart disease</u>					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		
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 _____ a.m. _____ p.m.		Month, Day, Year _____					
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 <u>30 Jan '59</u> to <u>6 Jan 60</u> and last saw him alive on <u>6 Jan 1960</u> Death occurred at <u>12:32</u> p.m. on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE <u>E. Lee M. Corble MD</u> (Degree or title)				22b. ADDRESS <u>Marshall Mo</u>		22c. DATE SIGNED <u>8 Jan 60</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>Jan. 9, 1960</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Slater</u>		23d. LOCATION (City, town, or county) <u>Slater, Missouri</u>		(State)
24. FUNERAL DIRECTOR <u>Haines Funeral Home, Slater, Mo.</u>				25. DATE RECD. BY LOCAL REG. <u>1-8-60</u>		26. REGISTRAR'S SIGNATURE <u>Cecil J. Read</u>	

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

FEB 10 1960

**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 Walter J. Haine

Licensed Embalmer No. 4557

P. O. Address: Slater

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.