S. No. 2
M—2-43
. 5-17-39
I X35697

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED MAY 8 1945

Registration District No. 278

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 14399

Primary Registration District No. 6024

Registrar's No. 6

1. PLACE OF DEATH:

(a) County Ray

(b) City or town Rural Polk Twp.
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: /
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution
(Specify whether
In this community
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Ray

(c) City or town Rural
(If outside city or town limits, write "RURAL")

(d) Street No.
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country

3. (a) PRINT FULL NAME SALLY S RIGGS

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex F | 5. Color or race W | 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife N R Riggs

6. (c) Age of husband or wife if alive 80 years

7. Birth date of deceased Aug (Month) 29 (Day) 1866 (Year)

8. AGE: Years 78 | Months 7 | Days 12 | If less than one day ____ hr. ____ min.

9. Birthplace Clark (City, town, or county) Mo (State or foreign country)

10. Usual occupation Housewife

11. Industry or business

MOTHER FATHER

12. Name Joseph McCrum

13. Birthplace Clark (City, town, or county) Mo (State or foreign country)

MOTHER

14. Maiden name Sarah K Fowler

15. Birthplace Clark (City, town, or county) Mo (State or foreign country)

16. (a) Informant Mrs Nelle Scott

(b) Address Lawson Mo

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Apr 13 1945 (Month) (Day) (Year)

(c) Place: burial or cremation Lawson Cemetery

18. (a) Signature of funeral director Jarman - Prichard

(b) Address Lawson Mo

19. (a) 4-12-45 (Date received local registrar) (b) W A Black (Registrar's signature)

1143 (Licensed Embalmer's Statement on Reverse Side)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 11
year 1945 hour 2 minute 10 P.M.

21. I hereby certify that I attended the deceased from April 1, 1945, to April 11, 1945, that I last saw her alive on April 10, 1945, and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Cardio-Renal Vascular disease	
Due to: Chronic Bronchiectasis	
Due to:	
Other conditions (Include pregnancy within 3 months of death):	
Major findings: Of operations: 1 2 0	PHYSICIAN
Of autopsy:	Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify)

(b) Date of occurrence

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? (Specify type of place)

While at work? (e) Means of injury

23. Signature Elsie E Burbank (M. D. or other)

Address Lawson Date signed Apr 12 1945

RECEIVED
District Health Office No. 4,
District File No.
Date Filed 5/7/45

MAY 10 1945

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.....

....., Registered Apprentice No.....

working under my personal supervision.

Signed Earl Ralph

Licensed Embalmer No. 3456

P. O. Address Ex. Eggs. 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.