NOV 5

32617

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

1. PLACE OF DEATH
County Adair — Registration District No. 4 — File No.
Township — Primary Registration District No. 3001 — Registered No. 154
City Kirksville (No. 416 S. Ely St. Ward)

2. FULL NAME Mrs Ella Rigdon
(a) Residence. No. St., Ward.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write* the word): Widowed

5A. ~~IF MARRIED~~, WIDOWED, ~~OR DIVORCED~~ ~~HUSBAND OF~~ (OR) ~~WIFE OF~~ Boston Rigdon Deed

6. DATE OF BIRTH (MONTH, DAY AND YEAR) March 7, 1858

7. AGE: 70 YEARS — MONTHS: 7 — DAYS: 1 — If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Adair Co. Mo.

PARENTS
10. NAME OF FATHER Wm Harris
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) St. Louis Co. Mo
12. MAIDEN NAME OF MOTHER Jane McKinney
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) Ky.

14. INFORMANT Josie Rigdon
(Address) Kirksville, Mo

15. FILED 10/12, 1928 C. H. Becker Dep. REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Oct 8 1928

17. I HEREBY CERTIFY, That I attended deceased from Oct 4, 1928, to Oct 7, 1928, that I last saw her alive on Oct 7, 1928 and that death occurred, on the date stated above, at 2:00 A m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Broncho pneumonia
93C 90B
(duration) yrs. mos. 5 ds.
CONTRIBUTORY (SECONDARY) Myocardial degeneration (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH? —
DID AN OPERATION PRECEDE DEATH? No. DATE OF
WAS THERE AN AUTOPSY? No
WHAT TEST CONFIRMED DIAGNOSIS? Physical signs
(Signed) J. W. Martin M.D.
10/8, 1928 (Address) Kirksville Mo

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. (See reverse side for additional space.)

19. PLACE OF BURIAL, CREMATION, OR REMOVAL: Bethel — DATE OF BURIAL: 10/9 1928

20. UNDERTAKER: G. B. Easley Jr. — ADDRESS: Brashear Mo

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

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CERTIFICATE OF DEATH

1. PLACE OF DEATH

County..... Registration District No..... File No.....

Township..... Primary Registration District No..... Registered No. .....!

City..... (No....., ...St.

2. FULL NAME .....

(a) Residence. No..... St., ...Ward. .....
(Usual place of abode) (If nonresident give city o

Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? y

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write* the word)

5A. IF MARRIED, WIDOWED, OR DIVORCED
HUSBAND OF
(OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR)

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ...hrs. or .....min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work .....

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) .....
(STATE OR COUNTRY)

PARENTS

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (CITY OR TOWN).....
(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (CITY OR TOWN).....
(STATE OR COUNTRY)

14.
INFORMANT .....
(Address)

15.
FILED....., 19..... .....
REGISTRAR

MEDICAL CERTIFICATE OF DE

16. DATE OF DEATH (MONTH, DAY AND YEAR)

17.
I HEREBY CERTIFY, That I attended de
.....,19....., to .....
that I last saw h..... alive on.....
death occurred, on the date stated above, at.....

THE CAUSE OF DEATH* WAS AS FOLLOWS:

.....
.....
.....
.....(duration).....y

CONTRIBUTORY.....
(SECONDARY)

.....(duration).....y

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH?.....

DID AN OPERATION PRECEDE DEATH?..... DATE OF.

WAS THERE AN AUTOPSY?.....!

WHAT TEST CONFIRMED DIAGNOSIS?.....

(Signed).....

, 19 (Address)

*State the DISEASE CAUSING DEATH, or in deaths fr
(1) MEANS AND NATURE OF INJURY, and (2) whether
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