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

Do not use this space.

1067

FEB 21 1929

39 1 6 37-8-9 63 1 1 2

1. PLACE OF DEATH
County Greene
Township Boone
City Ash Grove (No. ..... St. ..... Ward)
Registration District No. 316
Primary Registration District No. 4191
File No. 1
Registered No. 1

2. FULL NAME Edward A. Hixon
(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 M
4. COLOR OR RACE W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write* the word) Single

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Mar-23-1891

7. AGE

YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
27	10	90	

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

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

PARENTS
10. NAME OF FATHER Wm Hixon
11. BIRTHPLACE OF FATHER (CITY OR TOWN) Dade Co
(STATE OR COUNTRY) Mo.
12. MAIDEN NAME OF MOTHER Georgia Boner
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) .....
(STATE OR COUNTRY) Ky

14. INFORMANT Wm Hixon
(Address) Ash Grove Mo.

15. FILED 2.9. 1929 Dr Charles H Gray
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Jan 2 1929

17. I HEREBY CERTIFY, That I attended deceased from Aug, 1930, to Jan 2 1929 that I last saw him alive on Jan 2, 1929, and that death occurred, on the date stated above, at 10:40 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Arthritis Deformans
57 A
(duration) 8 yrs. ..... mos. ..... ds.

CONTRIBUTORY (SECONDARY) [illegible]
(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? Clinical
(Signed) Dr Charles H Gray, M. D
1-3, 1929 (Address) Ash Grove 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.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Ash Grove. Mo.
DATE OF BURIAL 1-3 1929

20. UNDERTAKER Galbraith Undt Co.
ADDRESS Ash Grove 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.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH.

County: Greene — Registration District No. 316 — File No.

Township — Primary Registration District No. 4191 — Registered No.

City: Oak Grove (No. ..... St. ..... Ward)

2. FULL NAME: David A. Wigson

(a) Residence. No. ..... St., ... Ward. (If nonresident give city or town and State)
(Usual place of abode)

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	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)
M	W	S

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Mar 23 - 190[illegible]

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
A	27	9	9	

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)

INFORMANT
(Address)

15. FILED 2/9, 19 29 D. Charles H. (Ivy) REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) JAN 2 1929 19

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

THE CAUSE OF DEATH* WAS AS FOLLOWS:

..... (duration) ...yrs. ...mos. ...ds.

CONTRIBUTORY (SECONDARY) ..... (duration) ...yrs. ...mos. ...ds.

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) ....., M. D.
, 19 (Address)

*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.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL	DATE OF BURIAL 19
20. UNDERTAKER	ADDRESS

SUPPLEMENTARY

A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

...lly supplied. AGE should b... s... may be properly classified. Exact stat... ...ION I. very important. Shou...

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