

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

Do not use this space.

6108

1. PLACE OF DEATH

County Franklin
Township Franklin
City Franklin (No. 5601)

Registration District No. 443
Primary Registration District No. 4261

File No. _____
Registered No. _____
St. _____ Ward _____

2. FULL NAME

(a) Residence. No. Franklin St., Franklin Ward _____
(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) widowed

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 7/1/1887

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
82 4 6

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer
(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) West Virginia

10. NAME OF FATHER Philip Wignall

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

12. MAIDEN NAME OF MOTHER Elizabeth Slighs

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

14. INFORMANT Mr. R. Gray
(Address) _____

15. FILED 7/25/31 Geo. B. Easley REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Feb 25 1931

17. I HEREBY CERTIFY, That I attended deceased from Feb 5, 1931, to Feb 25, 1931, that I last saw him alive on Feb 25, 1931, and that death occurred, on the date stated above, at 7:45 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Fourth degree burns of head, neck, arms & right leg. Accidental.

CONTRIBUTORY (SECONDARY) Curlings Ulcer
(duration) _____ yrs. _____ mos. _____ ds.

18. WHERE WAS DISEASE CONTRACTED 1555
IF NOT AT PLACE OF DEATH _____

DID AN OPERATION PRECEDE DEATH? No DATE OF _____

WAS THERE AN AUTOPSY? No

WHAT TEST CONFIRMED DIAGNOSIS?
(Signed) H. P. Schuch M.D.
, 19 _____ (Address) Franklin 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 I. O. O. F. Cemetery DATE OF BURIAL 2/27 1931

20. UNDERTAKER Geo. B. Easley ADDRESS Franklin 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 also important.

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ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH.

County Way Registration District No. 443 File No. _____
 Township Lyon Primary Registration District No. 5001 Registered No. _____
 City _____ (No. _____) St. _____ Ward _____

2. FULL NAME Benjamin Franklin Wigal
 (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** Wid
(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.
82 4 6

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)

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 _____

Her. B. Easley
 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Feb 25 1931

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

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Hospital degree burns of head back arms & right leg occurred while working in _____
Accidental

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 _____

20. UNDERTAKER _____

ADDRESS _____

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.

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

SUPPLEMENTARY

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