

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.

OCT 28 1935

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

Do not use this space.

30511

1. PLACE OF DEATH  
 94 County St. Francois Registration District No. 274  
 6 Township Flat River Primary Registration District No. 4468  
 6 City Flat River, Mo. (No. \_\_\_\_\_) St. \_\_\_\_\_ Ward \_\_\_\_\_

2. FULL NAME Mary Bernice Sigman  
 (a) Residence, No. Flat River, Mo. St. \_\_\_\_\_ Ward \_\_\_\_\_  
 (Usual place of abode)  
 Length of residence in city or town where death occurred 13 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED Single  
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Single  
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Nov. 17-1922  
 7. AGE YEARS 13 MONTHS 7 DAYS 27 If LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.  
 OCCUPATION 8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Schoolgirl  
 9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. \_\_\_\_\_  
 10. Date deceased last worked at this occupation (month and year) 7-1-35 11. Total time (years) spent in this occupation 7  
 12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Flat River, Mo.  
 13. NAME John Franklin Sigman  
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Flat River, Mo.  
 15. MAIDEN NAME Mary Black  
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) St. Francois County  
 17. INFORMANT (ADDRESS) John Franklin Sigman father  
 18. BURIAL, CREMATION, OR REMOVAL PLACE Flat River, Mo. DATE Sept 11 1935  
 19. UNDERTAKER (ADDRESS) Alvin W. Root Flat River, Mo.  
 20. FILED 10-6 1935 O. B. Harris Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Sept 9 1935  
 22. I HEREBY CERTIFY, That I attended deceased from Sept 6 1935 to Sept 9 1935  
 I last saw h. or alive on Sept 9 1935. Death is said to have occurred on the date stated above, at 4:30 P.M.  
 The principal cause of death and related causes of importance were as follows:  
acute tonsillitis  
Influenza  
Pneumonia Bronchial  
 Date of onset 9/5/35  
9/5/35  
9/8/35  
 Other contributory causes of importance: Chronic myocarditis 930  
 Name of operation None Date of \_\_\_\_\_  
 What test confirmed diagnosis? Physiol. Exam. Was there an autopsy? No  
 23. If death was due to external causes (violence), fill in also the following:  
 Accident, suicide, or homicide? L Date of injury \_\_\_\_\_, 19\_\_\_\_  
 Where did injury occur? L  
 (Specify city or town, county, and State)  
 Specify whether injury occurred in industry, in home, or in public place.  
 Manner of injury L  
 Nature of injury \_\_\_\_\_  
 24. Was disease or injury in any way related to occupation of deceased? No  
 If so, specify \_\_\_\_\_  
 (Signed) Paul L. Jones M. D.  
 (Address) Flat River, Mo.

