

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

7522  
Do not use this space.

1. PLACE OF DEATH

(a) County New Madrid Registration District No. 605  
(b) Township Commo Primary Registration District No. 7557 Registered No. \_\_\_\_\_  
(c) City Parma (d) Street No. \_\_\_\_\_ St. \_\_\_\_\_  
(If death occurred in Hospital or Institution, write its name instead of street and number)  
(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U.S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME Charles Luther Sigler

(a) Residence, No. \_\_\_\_\_ St.  (If nonresident, give city or town and State)  
(Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX <u>Male</u>	4. COLOR OR RACE <u>White</u>	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) <u>Married</u>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF <u>Minnie Sigler</u> (or) WIFE OF _____		
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) <u>1863 1-19</u>		
7. AGE	YEARS <u>76</u>	MONTHS <u>11</u>
	DAYS <u>23</u>	IF LESS than 1 day, ..... hrs. or ..... min.
OCCUPATION	8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. <u>Retired Manufg</u>	11. Total time (years) spent in this occupation
	9. Industry or business in which work was done, as saw mill, bank, etc.	
	10. Date deceased last worked at this occupation (month and year)	
FATHER	12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Springfield Ohio</u>	
	13. NAME <u>Samuel Sigler</u>	
MOTHER	14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Maryland</u>	
	15. MAIDEN NAME <u>Sophia Young</u>	
	16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Maryland</u>	
	17. INFORMANT <u>Minnie Sigler</u> (ADDRESS) <u>Parma mo</u>	
	18. BURIAL, CREMATION, OR REMOVAL PLACE <u>New Carlisle, Ohio</u> DATE <u>Jan-16-40</u>	
	19. FUNERAL DIRECTOR (NAME) <u>D. C. Knight</u> (ADDRESS) <u>Parma mo</u>	
	20. FILED <u>1-13 1940</u> <u>D. Gertrude</u> Local Registrar.	

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) January 12, 1940

22. I HEREBY CERTIFY, That I attended deceased from Jan 3, 1940, to Jan 12, 1940  
I last saw him alive on Jan 12, 1940 Death is said to have occurred on the date stated above, at 7:30 P.m.  
The principal cause of death and related causes of importance were as follows:  
Cardiac decomposition  
Acute Glomerular nephritis  
95%  
Other contributory causes of importance:  
Empyema of feet and face

Name of operation \_\_\_\_\_ Date of \_\_\_\_\_  
What test confirmed diagnosis? Time of death Was there an autopsy? No

23. If death was due to external causes (violence), fill in also the following:  
Accident, suicide, or homicide? \_\_\_\_\_ Date of injury \_\_\_\_\_, 19\_\_\_\_  
Where did injury occur? \_\_\_\_\_ (Specify city or town, county, and State)  
Specify whether injury occurred in industry, in home, or in public place.

Manner of injury \_\_\_\_\_  
Nature of injury \_\_\_\_\_

24. Was disease or injury in any way related to occupation of deceased?  
If so, specify \_\_\_\_\_ (Signed) Dr. Gertrude, M. D.  
(Address) Parma Ohio

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

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.

15 B

RECEIVED  
District Health Officer

District File Number 240-62

Date Filed 2/26/1

RECEIVED  
HEALTH DEPARTMENT

**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, \_\_\_\_\_

*T. C. Knight*

\_\_\_\_\_ or by \_\_\_\_\_

Registered Apprentice No. \_\_\_\_\_, working under my personal supervision.

Signed *Thomas C Knight*

Licensed Embalmer No. 2189

P. O. Address Parma 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, above space should be left blank.**

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 7522

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

Registration District No. 605

Primary Registration District No. 4359

Registrar's No. \_\_\_\_\_

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

1. PLACE OF DEATH:

(a) County New Madrid  
(b) City or town Corners  
(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 \_\_\_\_\_ (Specify whether \_\_\_\_\_)  
years, months or days

3. (a) PRINT FULL NAME Charles Luther Sigler

3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex m 5. Color or race w 6. (a) Single, widowed, married, divorced m

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband, or wife, if alive \_\_\_\_\_ years

7. Birth date of deceased (Month) (Day) (Year)

8. AGE: Years 76 Months 11 Days 23 If less than one day \_\_\_\_\_ min.

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

10. Usual occupation \_\_\_\_\_

11. Industry or business \_\_\_\_\_

12. Name \_\_\_\_\_

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

14. Maiden name \_\_\_\_\_

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

16. (a) Informant \_\_\_\_\_ (b) Address \_\_\_\_\_

17. (a) \_\_\_\_\_ (b) Date thereof (Month) (Day) (Year)

(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_ (b) Address \_\_\_\_\_

19. (a) \_\_\_\_\_ (b) \_\_\_\_\_ (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State \_\_\_\_\_ (b) County \_\_\_\_\_  
(c) City or town \_\_\_\_\_ (If outside city or town limits write "RURAL")  
(d) Street No. \_\_\_\_\_ (If rural, give location)  
(e) If foreign born, how long in U. S. A.? \_\_\_\_\_ years

20. DATE OF DEATH Month 1 day 12 year 1940 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_; that I last saw him alive on \_\_\_\_\_, 19\_\_\_\_; and that death occurred on the date and hour stated above.

Immediate cause of death Cardiac Decompensation acute glomerular nephritis

Due to \_\_\_\_\_

Due to Probably due to toxic condition from erysipelas

Other conditions Erysipelas of head and face

Major findings: \_\_\_\_\_ Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

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? \_\_\_\_\_

While at work \_\_\_\_\_ (Specify type of place) (e) Means of injury \_\_\_\_\_

23. Signature Geo. W. Husted (M. D. or other) \_\_\_\_\_ Address Parma Date signed \_\_\_\_\_

SUPPLEMENTAL

Duration \_\_\_\_\_ Underline the cause to which death should be charged statistically.

