

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.

MISSOURI STATE BOARD OF HEALTH

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

36235
Do not use this space.

1. PLACE OF DEATH

(a) County St. Charles Registration District No. 756
(b) Township Portage Primary Registration District No. 5997 Registered No. 16
(c) City _____ or _____ (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 58 yrs. 2 mos. 18 ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME Mary Diggins

(a) Residence, No. West Alton 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>Female</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 (OR) WIFE OF <u>John W Diggins</u>		
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) <u>Aug 23 1882</u>		
7. AGE	YEARS <u>58</u>	MONTHS <u>2</u>
	DAYS <u>16</u>	IF LESS than 1 day, hrs. or min.
OCCUPATION	8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. <u>Housework</u>	
	9. Industry or business in which work was done, as saw mill, bank, etc. <u>At Home</u>	
	10. Date deceased last worked at this occupation (month and year) <u>Oct 1 1940</u>	11. Total time (years) spent in this occupation <u>38 yrs</u>
12. BIRTHPLACE (CITY OR TOWN) <u>West Alton</u> (STATE OR COUNTRY) <u>Mo</u>		
FATHER	13. NAME <u>Fred Mintert</u>	
	14. BIRTHPLACE (CITY OR TOWN) <u>Germany</u> (STATE OR COUNTRY)	
MOTHER	15. MAIDEN NAME <u>U</u>	
	16. BIRTHPLACE (CITY OR TOWN) <u>U</u> (STATE OR COUNTRY)	
17. INFORMANT (ADDRESS) <u>Hubert Diggins</u> <u>West Alton MO</u>		
18. BURIAL, CREMATION, OR REMOVAL PLACE <u>St. Francis Cem.</u> <u>Portage Mo</u> DATE <u>Oct 11 1940</u>		
19. FUNERAL DIRECTOR (NAME) <u>Bauer and Hoehn</u> (ADDRESS) <u>Alto Ill</u>		
20. FILED <u>Oct 14 1940</u> <u>Rose Barnard</u> <u>Local Registrar</u>		

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Oct. 8 1940

22. I HEREBY CERTIFY, That I attended deceased from Oct 1 1940, to Oct 8 1940
I last saw her alive on Oct 8 1940 Death is said to have occurred on the date stated above, at 3:58 p.m.
The principal cause of death and related causes of importance were as follows:
Hemiplegia
Adenoma of Thyroid 1920
Arterio Sclerosis 1930
Other contributory causes of importance:
Name of operation _____ Date of _____
What test confirmed diagnosis? _____ Was there an autopsy? _____

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) [Signature], M. D.
(Address) _____

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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, or by.....

John A. Hoelker

....., Registered Apprentice No.....

working under my personal supervision.

Signed.....

James A. Hoelker Jr Hoelker

Licensed Embalmer No.....

11041

P. O. Address.....

Altus

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. 36235-
Registrar's No. _____

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. 756

Primary Registration District No. 3997

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

1. PLACE OF DEATH:

(a) County St Charles
(b) City or town Portage T.P.
(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 _____ years, months or days)

3. (a) PRINT FULL NAME Mary Dwiggins
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex F 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 58 Months 2 Days 16 If less than one day _____ h. _____ 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)
(Burial, cremation, or removal)

(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 Oct day 8 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 Hemiplegia

Due to Obstruction of Cerebral Arteries 5 days
Due to _____

Other conditions _____ (Include pregnancy within 3 months of death) 99W

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 C. A. Bernard (M. D. or other) M.D.
Address Portage No. 601 Date signed 12/18/40

SUPPLEMENTAL

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

