

REG APR 11 1941
109
Registration District No. _____

Primary Registration District No. 3008

Registrar's No. 74

1. PLACE OF DEATH:

(a) County CALLOWAY

(b) City or town FULTON
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: STATE HOSPITAL #1
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 21 days
(Specify whether I)

In this community _____
years, months or days)

2. USUAL RESIDENCE OF DECEASED: 14

(a) State Missouri (b) County WRIGHT

(c) City or town MOUNTAIN GROVE MO
(If outside city or town limits, write "RURAL")

(d) Street No. 0
(If rural, give location)

(e) If foreign born, how long in U. S. A. _____ years.

3. (a) PRINT FULL NAME WILLIAM WIGGIN

3. (b) If veteran, name war None

3. (c) Social Security No. None

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month MARCH day 14
year 1941 hour 5 minute 00 p. M.

4. Sex M / 5. Color or race W

6. (a) Single, widowed, married, divorced Wid.

6. (b) Name of husband or wife IDA GOTT

6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased FEB. 20 1861
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from FEB. 22
_____, 1941, to MARCH 14, 1941;
that I last saw him alive on MARCH 14, 1941;
and that death occurred on the date and hour stated above.

Immediate cause of death BRONCHO PNEUMONIA

Due to SENILITY

Due to _____

Duration
12 hrs

8. AGE: Years 80 Months 0 Days 24
If less than one day _____ hr. _____ min.

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

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

10. Usual occupation FARMER

11. Industry or business _____

MOTHER FATHER { 12. Name PK 9

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

14. Maiden name PK

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

Major findings:
Of operations _____

Of autopsy _____

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

16. (a) Informant HOSPITAL RECORDS

(b) Address _____

17. (a) Interment (b) Date thereof MARCH 10 1941
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Mt. Grove Mo.

18. (a) Signature of funeral director Russell Jones

(b) Address Mt. Grove Mo.

19. (a) 3-104-41 (b) R. H. Cross
(Date received local registrar) (Registrar's signature)

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? No
(Specify type of place) _____
While at work? _____ (e) Means of injury _____

23. Signature John A. Carter (M. D. or other) M. D.
Address State Hospital #1 Date signed _____

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

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.....

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

Signed..... *Richard Bonker*

Licensed Embalmer No..... *3848*

P. O. Address..... *1st, Grove, 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, fact should be so stated above.