

Health,
Welfare
Public
Service

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-017144
STATE FILE NUMBER

FILED APR 21 1958

Registration District No. 373 Primary Registration District No. 6268 Registrar's No. 1D

300
1-57
20

1. PLACE OF DEATH a. COUNTY WEBSTER		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before death) a. STATE MO 11209 b. COUNTY WEBSTER	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN NORTH VIEW		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN NORTH VIEW MO
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION		Length of stay in lb	d. STREET ADDRESS (If outside, give location)
			Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Middle Last JAMES L WIED CRIGER	4. DATE OF DEATH Month Day Year APR 9 1958
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5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH NOV 13 1877	9. AGE (In years last birthday) 80	10. FUNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RET FARMER	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) MISSOURI 0	12. CITIZEN OF WHAT COUNTRY? U.S.A
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13a. FATHER'S NAME JAMES CRIGER	13b. MOTHER'S MAIDEN NAME ALICE PENDERGRASS	14. NAME OF HUSBAND OR WIFE VELMA
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) NO	16. SOCIAL SECURITY NO.	17. INFORMANT VELMA CRIGER	Address NORTHVIEW MO
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Consecutive Heart Failure Valvular Heart Disease Cerebral artery thrombosis 4214H		INTERVAL BETWEEN ONSET AND DEATH 2 months 30 year 3 weeks
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) arteriosclerotic cranial ganglions 3 weeks.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Basal cell Carcinoma left cheek 3 yrs.		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>

20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)
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20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.	20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION	COUNTY	STATE
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21. I attended the deceased from 10/20/55 to 4/9/58 and last saw her ^{her} _{him} alive on 4/6/58 . Death occurred at 530 A m on the date stated above; and to the best of my knowledge, from the causes stated.
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22a. SIGNATURE (Degree or title) A. M. Macdonell M.D.	22b. ADDRESS Marshfield, Mo	22c. DATE SIGNED 4/12/58
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23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE 4-11-1958	23c. NAME OF CEMETERY OR CREMATORY PLEASANT GROVE	23d. LOCATION (City, town, or county) (State) WEBSTER CO MO
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24. FUNERAL DIRECTOR BARBER-EDWARDS	ADDRESS MARSHFIELD	25. DATE RECD. BY LOCAL REG. 4-14-58	26. REGISTRAR'S SIGNATURE <i>[Signature]</i>
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(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

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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, Student Embalmer No. working under my personal supervision.

Student
Signature of Student Embalmer

Signed *George Stapp*

Licensed Embalmer No. *3161*
P. O. Address *St. Louis, 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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.