

t. Health,
& Welfare
S. Public
th Service

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-028769
STATE FILE NUMBER

S. 300
v. 1-57

AUG 18 1958		Registration District No. 128		Primary Registration District No. 2000		Registrar's No. 794	
1. PLACE OF DEATH a. COUNTY Greene				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Greene			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Springfield		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN Springfield		0396 Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 820 N. Benton Ave.			Length of stay in lb 18 years		d. STREET ADDRESS 506 W. Lynn		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First MABEL			Middle BIGELOW		Last ARCHER		4. DATE OF DEATH August 11, 1958 Month Day Year
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH June 3, 1870		9. AGE (In years of birthday) 88	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (City and state or country) Kalamazoo County, Mich.		12. CITIZEN OF WHAT COUNTRY? U.S. A.	
13a. FATHER'S NAME Edward M. Bigelow			13b. MOTHER'S MAIDEN NAME Maria L. Alchin		14. NAME OF HUSBAND OR WIFE (Deceased) William T. Archer		
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. None		17. INFORMANT Address Mrs. Buell Wilson, Rt. #2, Buffalo, Mo			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Heart Disease						INTERVAL BETWEEN ONSET AND DEATH ?	
Conditions, if any, which gave rise to above cause (a), stating the under- lying cause last. DUE TO (b) Generalized Arteriosclerosis						?	
DUE TO (c) 4200							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)						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.)				
20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.							
20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE <input type="checkbox"/> WORK AT WORK		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION		COUNTY STATE	
21. I attended the deceased from 11-29-57 to 8-11-58 and last saw her alive on 7-31-58 Death occurred at 4:15 A.M. on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE E. L. Simpson, M.D.				22b. ADDRESS Springfield, Missouri		22c. DATE SIGNED 8-11-58	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE 8-13-58	23c. NAME OF CEMETERY OR CREMATORY Conway Cemetery		23d. LOCATION (City, town, or county) Conway, Missouri (State)		
24. FUNERAL DIRECTOR AYRE-GOODWIN, SPRINGFIELD, MO.			25. DATE RECD. BY LOCAL REG. 8-12-58		26. REGISTRAR'S SIGNATURE Effie E. Mellon		

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
MEDICAL CERTIFICATION

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.

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 

Licensed Embalmer No. 4594

P. O. Address Springfield, 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.