

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-045295

STATE FILE NUMBER

FILED DEC 29 1958

Registration District No. 311

Primary Registration District No. 4456

Registrar's No. 45

300
1-57

| | | | |
|---|---|---|---|
| 1. PLACE OF DEATH a. COUNTY <u>ST. CLAIR</u> | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>CLAIR</u> | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>APPLETON CITY</u> | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | c. CITY OR TOWN <u>EL DORADO SPRINGS</u> 0201 Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Ellett Mid Hosp.</u> | | Length of stay in lb <u>6 Mo.</u> | d. STREET ADDRESS (If outside, give location) <u>700 S. GRAND</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print) First Middle Last <u>Amy Cynthia Jigg</u> | | | 4. DATE OF DEATH Month Day Year <u>Dec 20-58</u> |
| 5. SEX <u>F</u> | 6. COLOR OF RACE <u>W</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>Nov. 14-1905</u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Physical therapist</u> | | 10b. KIND OF BUSINESS OR INDUSTRY | 9. AGE (In years last birthday) Months Days Hours Min. <u>53 1 6</u> |
| 11. BIRTHPLACE (City and state or country) <u>ST. CLAIR Co. Mo.</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13a. FATHER'S NAME <u>Chas D. Murray</u> | | 13b. MOTHER'S MAIDEN NAME <u>Veronica Masasma</u> | 14. NAME OF HUSBAND OR WIFE <u>None</u> |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. <u>550-26-3990</u> | 17. INFORMANT Address <u>Ed Murray Monticello Mo.</u> |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>C.A. OF BRAIN</u> | | | INTERVAL BETWEEN ONSET AND DEATH <u>10 MOS.</u> |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>1930</u> | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input checked="" type="checkbox"/> | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) <u>1930</u> | | |
| 20c. TIME OF INJURY Hour . Month, Day, Year a.m. p.m. | | | |
| 20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" 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 |
| 21. I attended the deceased from <u>MAR 1958</u> to <u>DEC 20 1958</u> and last saw her/him alive on <u>Dec 20 1958</u> Death occurred at <u>1:45</u> P m on the date stated above; and to the best of my knowledge, from the causes stated. | | | |
| 22a. SIGNATURE (Degree or title) <u>Robert H. Braunshagen MD</u> | | 22b. ADDRESS <u>Appleton City, Mo.</u> | 22c. DATE SIGNED <u>Dec 22 1958</u> |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | 23b. DATE <u>12-23-58</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>Pleasant Grove</u> | 23d. LOCATION (City, town, or county) (State) <u>St. Clair Co, Mo.</u> |
| 24. FUNERAL DIRECTOR ADDRESS <u>Oscar Eckhoff Appleton City, Mo.</u> | | 25. DATE RECD. BY LOCAL REG. <u>Dec 29 1958</u> | 26. REGISTRAR'S SIGNATURE <u>Chas Abney</u> |

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 *Wesley E. Holtz*

Licensed Embalmer No. *3942*

P. O. Address *Appleton, W.*

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.