

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-014576

STATE FILE NUMBER

FILED APR 29 1959 Registration District No. 316 Primary Registration District No. 3060 Registrar's No. 147

1. PLACE OF DEATH a. COUNTY <b>St. Francois</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before a. STATE <b>Missouri</b> b. COUNTY <b>St. Francois</b>				
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Farmington, Mo.</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <b>Festus</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION			Length of stay in 1b		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 <b>Gilbert</b> Middle <b>Ignatius</b> Last <b>Rigdon</b>				4. DATE OF DEATH Month <b>April</b> Day <b>17</b> Year <b>1959</b>				
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> / DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Oct. 15, 1913</b>		9. AGE (In years at birthday) <b>45</b>	IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/>	IF UNDER 24 HRS. Hours <input type="checkbox"/> Min. <input type="checkbox"/>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>laborer</b>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) <b>St. Genevieve Co., Mo.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13a. FATHER'S NAME <b>Louis Rigdon</b>			13b. MOTHER'S MAIDEN NAME <b>Lizzie A. Vogt</b>		14. NAME OF HUSBAND OR WIFE <b>Rita Schwartz</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No, or unknown) (If yes, give us or dates of service) <b>NO</b>			16. SOCIAL SECURITY NO. <b>498-14-8932</b>		17. INFORMANT Address <b>Simon J. Rigdon 917 E. College Farmington, Mo.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic Heart Disease</b>							INTERVAL BETWEEN ONSET AND DEATH <b>7 mo yrs.</b>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause lost. } 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) <b>Postal Craniosis</b>							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.) <b>4200</b>					
20c. TIME OF INJURY Hour _____ a.m. _____ p.m.								
20d. INJURY OCCURRED WHILE AT WORK <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
21. I attended the deceased from <b>Apr 6, 1959</b> to <b>Apr. 17, 1959</b> and last saw him alive on <b>Apr. 14, 1959</b> Death occurred at <b>6:30 A.M.</b> m or the date stated above, and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE (Degree or title) <b>R. A. Hunkstader MD</b>					22b. ADDRESS <b>Farmington Mo</b>		22c. DATE SIGNED <b>4/18/59</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>April 20, 1959</b>	23c. NAME OF CEMETERY OR CREMATORY <b>St. Catherine Cemetery</b>		23d. LOCATION (City, town, or county) <b>Coffman,</b>		STATE <b>Mo.</b>	
24. FUNERAL DIRECTOR ADDRESS <b>C.H. Cozean, Farmington, Mo.</b>				25. DATE RECD. BY LOCAL REG. <b>Apr. 20, 1959</b>		26. REGISTRAR'S SIGNATURE <b>Esther Rudloff</b>		

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

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 *Ch. Howell*

Licensed Embalmer No. *3670*

P. O. Address *San Antonio*

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.