

**MISSOURI STATE BOARD OF HEALTH  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH**

Do not use this space.

37307

**1. PLACE OF DEATH**

County Jackson Registration District No. 411  
 Township Patton Primary Registration District No. 20.08  
 City Patton (No. \_\_\_\_\_) St. \_\_\_\_\_ (Ward \_\_\_\_\_)

File No. \_\_\_\_\_  
 Registered No. 515

**2. FULL NAME**

(a) Residence. No. St. Joseph St. Joseph Ward. \_\_\_\_\_  
 (Usual place of abode) \_\_\_\_\_ (If nonresident give city or town and State)  
 Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

**PERSONAL AND STATISTICAL PARTICULARS**

**MEDICAL CERTIFICATE OF DEATH**

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Widowed

16. DATE OF DEATH (MONTH, DAY AND YEAR) Nov 27 19 28

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Widowed

17. I HEREBY CERTIFY That I attended deceased from \_\_\_\_\_ 19\_\_\_\_ to \_\_\_\_\_ 19\_\_\_\_ that I last saw him alive on \_\_\_\_\_ 19\_\_\_\_, and that death occurred, on the date stated above, at \_\_\_\_\_ 4306m.

6. DATE OF BIRTH (MONTH, DAY AND YEAR) April 24-1858

**THE CAUSE OF DEATH\* WAS AS FOLLOWS:**

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.  
70 | 7 | 3

Cerebral Hemorrhage

8. OCCUPATION OF DECEASED  
 (a) Trade, profession, or particular kind of work Retired  
 (b) General nature of industry, business, or establishment in which employed (or employer) \_\_\_\_\_  
 (c) Name of employer \_\_\_\_\_

(duration) yrs. mos. ds. 7  
 CONTRIBUTORY (SECONDARY) 740  
 (duration) yrs. mos. ds.

9. BIRTHPLACE (CITY OR TOWN) Nashville  
 (STATE OR COUNTRY) Tenn

18. WHERE WAS DISEASE CONTRACTED  
 IF NOT AT PLACE OF DEATH: \_\_\_\_\_

10. NAME OF FATHER Samuel Riggs

DID AN OPERATION PRECEDE DEATH: \_\_\_\_\_ DATE OF \_\_\_\_\_  
 WAS THERE AN AUTOPSY: \_\_\_\_\_

11. BIRTHPLACE OF FATHER (CITY OR TOWN) Unknown  
 (STATE OR COUNTRY) \_\_\_\_\_

WHAT TEST CONFIRMED DIAGNOSIS?  
 (Signed) R. M. Stovinec, M. D.  
11/27. 19 28 (Address) North City

12. MAIDEN NAME OF MOTHER Unknown

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Unknown  
 (STATE OR COUNTRY) \_\_\_\_\_

\*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

14. INFORMANT Miss Addie R. Satchell  
 (Address) South. Passage, New Jersey

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Castanella Cemetery DATE OF BURIAL 11/28 19 28

15. FILED 11-28, 19.28 Dr. Benson Clark  
 REGISTRAR

20. UNDERTAKER North City ADDRESS North City Mo.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

RECORD

