

FILED JAN 5 1944
 749

Registration District No. _____ Primary Registration District No. 1002

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:
 (a) County Jackson
 (b) City or town Kansas City
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
K. C. General Hospital No. 1
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 16 hrs. 55 min.
(Specify whether years, months or days)

3. (a) PRINT FULL NAME Robert R. Rigg
 3. (b) If veteran, name war no
 3. (c) Social Security No. 495 10 9522

4. Sex Male 5. Color or Race White 6. (a) Single, widowed, married, divorced, Married
 6. (b) Name of husband or wife Eleanor Rigg 6. (c) Age of husband or wife if alive 42 years
 7. Birth date of deceased Nov 7 1895
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	48	1	14	_____ hr. _____ min.

9. Birthplace Lowell Mass.
(City, town, or county) (State or foreign country)

10. Usual occupation Construction Worker

11. Industry or business _____

MOTHER FATHER {
 12. Name W. E. Rigg
 13. Birthplace England
(City, town, or county) (State or foreign country)
 14. Maiden name Emma Moron
 15. Birthplace Ireland
(City, town, or county) (State or foreign country)

16. (a) Informant Eleanor Rigg
 (b) Address 1010 west 16 St Terrace
 17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 23 1943
(Month) (Day) (Year)
 (c) Place: burial or cremation Green Lawn Cem.

18. (a) Signature of funeral director Mrs C. L. Forster
 (b) Address 918 Brooklyn

19. (a) 12-23-43 (Date received local registrar) (b) T. E. Brown (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
 (a) State Missouri (b) County Jackson
 (c) City or town Kansas City
(If outside city or town limits, write "RURAL")
 (d) Street No. 1010 W. 16 Terr.
(If rural, give location)
 (e) Citizen of foreign country? _____ (Yes or No)
 If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month December day 21
 year 1943 hour 4 minute 40 P.M.

21. I hereby certify that I attended the deceased from December 20 1943 to December 21 1943
 that I last saw him alive on December 21 1943
 and that death occurred on the date and hour stated above.

Immediate cause of death Internal Hemorrhage
(Stomach region)

Due to _____
 Due to _____
 Other conditions _____
(Include pregnancy within 3 months of death)

Major findings:
 Of operations _____
 Of autopsy _____

Duration _____
 PHYSICIAN _____
 Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
 (a) Accident, suicide, or homicide (specify) _____
 (b) Date of occurrence _____
 (c) Where did injury occur? _____
(City or town) (County) (State)
 (d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work? _____ (Specify type of place)
 (e) Means of injury _____
 23. Signature Amey R. Thon (M. D. or other)
 Address Med. Dir. Gen'l Hosp. Date signed 12-22-43

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.....

....., Registered Apprentice No.....
working under my personal supervision.

Signed *Denzil C. Browning*.....

Licensed Embalmer No. *2724*.....

P. O. Address *W.C. 210*.....

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 this body is not embalmed, fact should be so stated above.