

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **37770**

DEC 15 1952

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 42 PRIMARY REG. DIST. NO. 1000 Registrar's No. 1293

1. PLACE OF DEATH a. COUNTY <b>Buchanan</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Buchanan</b>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>St. Joseph</b>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>St. Joseph</b>	
c. LENGTH OF STAY (in this place) <b>24 yrs</b>		d. STREET ADDRESS (If rural, give location) <b>2305 Cedar St.</b>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>2305 Cedar St.</b>			

3. NAME OF DECEASED (Type or Print) a. (First) <b>CLYDA</b>	b. (Middle)	c. (Last) <b>RIGGS</b>	4. DATE OF DEATH (Month) (Day) (Year) <b>Dec 5, 1952</b>
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5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Married</b>	8. DATE OF BIRTH <b>Feb. 14, 1897</b>	9. AGE (In years last birthday) <b>55</b>	IF UNDER 1 YEAR Months	IF UNDER 1 YEAR Days	IF UNDER 1 HR. Hours	IF UNDER 1 HR. Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Fore Lady</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>Mfg. Co.</b>	11. BIRTHPLACE (State or foreign country) <b>Stewartsville, Missouri</b>	12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
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13a. FATHER'S NAME <b>Unknown</b>	13b. MOTHER'S MAIDEN NAME <b>Unknown</b>	14. NAME OF HUSBAND OR WIFE <b>Samuel H. Riggs</b>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>	16. SOCIAL SECURITY NO. <b>491-09-3984</b>	17. INFORMANT'S SIGNATURE OR NAME <b>Mr Samuel H. Riggs</b>	ADDRESS <b>2305 Cedar, City</b>
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)  <i>*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.</i>	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Malignant Melanoma</b>		INTERVAL BETWEEN ONSET AND DEATH <b>3 Mo.</b>
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____		
	II. OTHER SIGNIFICANT CONDITIONS. Conditions contributing to the death but not related to the disease or condition causing death.		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
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22. I hereby certify that I attended the deceased from Sept 3, 1952, to Dec 5, 1952, that I last saw the deceased alive on Dec 5, 1952, and that death occurred at 11:30 A.M., from the causes and on the date stated above.

23a. SIGNATURE <i>[Signature]</i> (Degree or title)	23b. ADDRESS <b>420 N. 8<sup>th</sup> City</b>	23c. DATE SIGNED <b>12/10/52</b>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	24b. DATE <b>12-8-52</b>	24c. NAME OF CEMETERY OR CREMATORY <b>Memorial Park</b>	24d. LOCATION (City, town, or county) (State) <b>St. Joseph, Mo.</b>
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DATE REC'D BY LOCAL REG. <b>Dec 11, 1952</b>	REGISTRAR'S SIGNATURE <i>[Signature]</i>	25. FUNERAL DIRECTOR'S SIGNATURE <b>Heaton-Bowman Funeral Home</b>	ADDRESS <b>St. Joseph, Mo.</b>
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

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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 .....  
Student Embalmer

Signed *William Spalding* \_\_\_\_\_

Licensed Embalmer No. *4535* \_\_\_\_\_

P. O. Address *319 S. 10<sup>th</sup> St. N. Phoenix* \_\_\_\_\_

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.