

**JURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH**

**59-035058**

FILED VS. NOV 5 1959 0 2

Registration District No. Primary Registration District No. Registrar's No.

STATE FILE NUMBER

ENDED

1. PLACE OF DEATH a. COUNTY <b>ANDREW</b>		2. USUAL RESIDENCE (Where deceased lived) If institution: Residence before admission a. STATE <b>MO</b> b. COUNTY <b>DEKALB</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) <b>SAVANNAH</b>		Length of stay in 1b	c. CITY OR TOWN <b>MAYSVILLE</b>
c. FULL NAME OF (IF NOT in hospital, give location) <b>SHADY LAWN REST. HOME</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>MAYSVILLE</b>
		Yes <input type="checkbox"/> No <input type="checkbox"/>	Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) <b>JENNIE RIGGS</b>			4. DATE OF DEATH <b>OCT. 22-1959</b>		
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>4-2-1870</b>	9. AGE (last birthday) <b>89</b>	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <b>MT. GILEAD OHIO</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.</b>
13a. FATHER'S NAME <b>GEORGE WINTER</b>		13b. MOTHER'S MAIDEN NAME <b>AMANDA NIMOX</b>		14. NAME OF HUSBAND OR WIFE <b>I.T. RIGGS</b>	
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.		17. INFORMANT <b>Hester Winters, Maysville, MO</b>	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) <b>Arteriosclerotic heart disease</b>		<b>2 yrs.</b>
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) <b>fractured right hip, fell at the rest home</b>	PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown
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19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input checked="" 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>Fell at rest home</b>
20c. TIME OF INJURY Hour a.m. p.m. <b>9-21-59</b>		

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, pdg., etc.) <b>Rest Home Savannah Andrew Mo.</b>	20f. CITY, TOWN, OR LOCATION <b>SAVANNAH ANDREW MO.</b>	COUNTY	STATE
21. I attended the deceased from <b>8-25-59</b> to <b>10-20-59</b> and last saw her/him alive on <b>10-20-59</b> Death occurred at _____ on the date stated above, and to the best of my knowledge, from the causes stated.				

22a. SIGNATURE <b>Warren Baker M.D.</b>		22b. ADDRESS <b>703 West Highway, Savannah Missouri</b>		22c. DATE SIGNED
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>REMOVAL</b>	23b. DATE <b>10-24-59</b>	23c. NAME OF CEMETERY OR CREMATORY <b>MEMORIAL PARK</b>	23d. LOCATION (city, town, or county) (State) <b>ST. JOSEPH - MO</b>	
24. FUNERAL DIRECTOR <b>FILCHER FUNERAL HOME</b>		25. DATE RECD. BY LOCAL REG. <b>10-27-59</b>		26. REGISTRAR'S SIGNATURE <b>Kellian Drake</b>
ADDRESS <b>MAYSVILLE MO</b>		27. (Used Embalmer's Statement on Reverse Side)		

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. P107 20

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate <sup>will be</sup> was embalmed by me

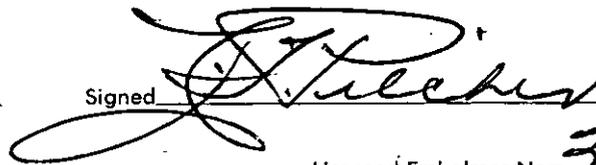
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Student \_\_\_\_\_

Signature of Student Embalmer

Signed



License of Embalmer No. 3960

P. O. Address Maple Hill, Mo.

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.