

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS JUN 28 1960

-60-024225

DED

Registration District No. 314 Primary Registration District No. 4458-6059/35 Registrar's No. 35

STATE FILE NUMBER

| | | | | | | | | |
|---|---|---|--|--|--|--|---|-------|
| 1. PLACE OF DEATH a. COUNTY St. Clair | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY St. Clair | | | | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Collins rural | | Length of stay in 1b | | c. CITY OR TOWN Collins | | Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | | |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Route # 1 | | | Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | | d. STREET ADDRESS (If outside, give location) Route # 1 | | Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First William Middle Benjamin Last Riggs | | | | 4. DATE OF DEATH Month June Day 16 Year 1960 | | | | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> | | 8. DATE OF BIRTH 5/28/91 | 9. AGE (last birthday) 69 | IF UNDER 1 YEAR Months Days | IF UNDER 24 HR Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farming | | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (City and state or country) Missouri | | 12. CITIZEN OF WHAT COUNTRY USA | |
| 13a. FATHER'S NAME Bernice Riggs | | | 13b. MOTHER'S MAIDEN NAME Jane Rice | | | 14. NAME OF HUSBAND OR WIFE Bernice Riggs | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes WW # 1 | | | 16. SOCIAL SECURITY NO. 493-12-0523A | | 17. INFORMANT Address Bernice Riggs, Collins Missouri | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion | | | | | | | INTERVAL BETWEEN ONSET AND DEATH 1/2 hour | |
| 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) | | | | | PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown | | | |
| 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.) | | | | | | |
| 20c. TIME OF INJURY Hour _____ a.m. _____ p.m. Month, Day, Year _____ | | | | | | | | |
| 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 June 16 1960 to June 16 1960 and last saw him alive on June 16 1960 . Death occurred at 5:00 P.M. on the date stated above, and to the best of my knowledge, from the causes stated. <i>Was dead when I arrived.</i> | | | | | | | | |
| 22a. SIGNATURE (Degree or title) J. E. D. Brown Do | | | | 22b. ADDRESS Collins Mo | | | 22c. DATE SIGNED 6/17/60 | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 23b. DATE 6/19/60 | 23c. NAME OF CEMETERY OR CREMATORY Robinson | | 23d. LOCATION (City, town, or county) Collins Missouri | | (State) | | |
| 24. FUNERAL DIRECTOR ADDRESS Goodrich Funeral Home, Osceola Mo. | | | | 25. DATE RECD. BY LOCAL REG. 6-24-60 | | 26. REGISTRAR'S SIGNATURE Ruth Seever | | |

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

JUN 30 1960

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by _____ or by _____, Student Embalmer No. _____ working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed J.B. Goodrich

Licensed Embalmer No. 3038

P. O. Address Osceola

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.