

MURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS NOV 9 1960

-60-039375

STATE FILE NUMBER

Registration District No. 297 Primary Registration District No. 6022 Registrar's No. 133

1. PLACE OF DEATH a. COUNTY <u>Ray</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Ray</u>					
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Richmond</u> <u>TWSP</u>		Length of stay in 1b <u>3 Months</u>		c. CITY OR TOWN <u>Orrick</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Ray County Memorial Hosp.</u>			Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		d. STREET ADDRESS (If outside, give location)		Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <u>Hazel</u> Middle <u>Laura</u> Last <u>Riggs</u>				4. DATE OF DEATH Month <u>Nov.</u> Day <u>3</u> Year <u>1960</u>					
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <u>4-11-1904</u>	9. AGE (last birthday) <u>56</u>	IF UNDER 1 YEAR Months	IF UNDER 24 HR Days	IF UNDER 24 Min. Hours	IF UNDER 24 Min. Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) <u>Richmond, Missouri</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>		
13a. FATHER'S NAME <u>Lucian Sidney Davis</u>			13b. MOTHER'S MAIDEN NAME <u>Laura Ann Ware</u>			14. NAME OF HUSBAND OR WIFE <u>Herbert Riggs</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO. <u>unknown</u>		17. INFORMANT Address <u>Husband Orrick, Missouri</u>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Accident</u> DUE TO (b) <u>Arterio-sclerosis</u> DUE TO (c) <u>Metastatic Ca. (Sigmoid)</u> 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 checked="" type="checkbox"/> No <input type="checkbox"/> Unknown								INTERVAL BETWEEN ONSET AND DEATH <u>6 wks</u> <u>?</u> <u>2 yrs</u>	
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 <u>July 1-60</u> to <u>11-3-60</u> and last saw her/him alive on <u>11-3-60</u> Death occurred at <u>7:00 PM.</u> on the date stated above, and to the best of my knowledge, from the causes stated.									
22a. SIGNATURE <u>E. B. Ray</u> (Name or title)					22b. ADDRESS <u>Richmond</u>			22c. DATE SIGNED <u>11-5-60</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>Nov. 6, 1960</u>	23c. NAME OF CEMETERY OR CREMATORY <u>New Garden Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Excelsior Springs, Mo.</u>				
24. FUNERAL DIRECTOR <u>Wilbur McAfee</u> ADDRESS <u>Orrick, Mo.</u>			25. DATE RECD. BY LOCAL REG. <u>11-6-1960</u>		26. REGISTRAR'S SIGNATURE <u>Maluel Jackson</u>				

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

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 _____
Signature of Student Embalmer

Signed Charles A. Tyler

Licensed Embalmer No. 453

P. O. Address Liberty

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.