

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

**-61-016015**  
STATE FILE NUMBER

Registration District No. 317 Primary Registration District No. 541 Registrar's No. 1087

AMENDED

**FILED MAY 8 1961**

DATE AMENDED

INSTEAD OF

DOCUMENT

<b>1. PLACE OF DEATH</b> a. COUNTY <b>St. Louis</b> b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Clayton</b> Length of stay in 1b <b>DOA</b>		<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>St. Louis</b> c. CITY OR TOWN <b>Manchester</b> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> d. STREET ADDRESS (If outside, give location) <b>411 Coventry Lane</b> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) First <b>Robert</b> Middle <b>Arley</b> Last <b>Riggs</b>		<b>4. DATE OF DEATH</b> Month <b>April</b> Day <b>19</b> Year <b>1961</b>	

<b>5. SEX</b> <b>Male</b>	<b>6. COLOR OR RACE</b> <b>White</b>	<b>7. Married</b> <input checked="" type="checkbox"/> <b>Never Married</b> <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <b>11/21/1925</b>	<b>9. AGE (last birthday)</b> <b>35</b>	IF UNDER 1 YEAR Months Days Hours Min.
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Physician &amp; Surgeon</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>Osteopathic</b>		<b>11. BIRTHPLACE</b> (City and state or country) <b>Canton, Mo.</b>	
<b>13a. FATHER'S NAME</b> <b>Elda A. Riggs</b>		<b>13b. MOTHER'S MAIDEN NAME</b> <b>Esther G. Harrison</b>		<b>14. NAME OF HUSBAND OR WIFE</b> <b>Bonnie Mae Riggs</b>	

<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes, give war or dates of service) <b>Yes WW II</b>	<b>16. SOCIAL SECURITY NO.</b> <b>Unknown</b>	<b>17. INFORMANT</b> Address <b>Bonnie Mae Riggs, Manchester, Mo.</b>
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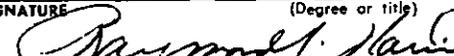
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Gunshot wound of the chest</b> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH
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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
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<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	<b>20a. ACCIDENT</b> <input type="checkbox"/> <b>SUICIDE</b> <input checked="" type="checkbox"/> <b>HOMICIDE</b> <input type="checkbox"/>	<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in PART I or PART II of item 18.) <b>Self inflicted gunshot wound of chest</b>
<b>20c. TIME OF INJURY</b> Hour <b>7:00 approx</b> Month, Day, Year <b>MO 4/19/61</b>		

<b>20d. INJURY OCCURRED WHILE AT WORK</b> <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	<b>20e. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>rumpus room at home</b>	<b>20f. CITY, TOWN, OR LOCATION</b> COUNTY STATE <b>Manchester St. Louis Missouri</b>
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21. I attended the deceased from \_\_\_\_\_, to \_\_\_\_\_ and last saw her/him alive on \_\_\_\_\_  
 Death occurred at \_\_\_\_\_ m on the date stated above, and to the best of my knowledge, from the causes stated.

<b>22a. SIGNATURE</b> (Degree or title)  <b>Coroner Clayton, Mo.</b>	<b>22b. ADDRESS</b>	<b>22c. DATE SIGNED</b> <b>4/28/61</b>
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<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <b>Removal</b>	<b>23b. DATE</b> <b>4-20-61</b>	<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>LOCAL</b>	<b>23d. LOCATION</b> (City, town, or county) (State) <b>Canton, Mo.</b>
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<b>24. FUNERAL DIRECTOR</b> ADDRESS <b>Albert H. Hoppe, Inc., 4700 Washington Blvd.</b>	<b>25. DATE RECD. BY LOCAL REG.</b> <b>4-20-61</b>	<b>26. REGISTRAR'S SIGNATURE</b> 
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ITEM NO. SHOULD READ

BY AFFIDAVIT OF

MEDICAL CERTIFICATION

1961 MAY 8 SA

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 Jas M. Dunbar  
Licensed Embalmer No. 13653  
P. O. Address St. Louis, 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.