

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-62-037829

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. 43 Primary Registration District No. 3007 Registrar's No. 1045

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

FILED OCT 16 1962

VS 300
Rev. 4/59

DATE AMENDED

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AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

ITEM NO. SHOULD READ

DOCUMENT

1. PLACE OF DEATH a. COUNTY BUTLER		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MISSOURI b. COUNTY CAPE GIRARDEAU	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN POPLAR BLUFF		Length of stay in lb 10 DAYS	c. CITY OR TOWN JACKSON Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION VA HOSPITAL		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) RFD # 1, Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First ADRIAN Middle LESTER Last RIGGS			4. DATE OF DEATH Month OCT Day 8, Year 1962			
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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 6-4-03	9. AGE (last birthday) 59	IF UNDER 1 YEAR Months Days	IF UNDER 24 HR Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ARCHITECT	10b. KIND OF BUSINESS OR INDUSTRY UNKNOWN	11. BIRTHPLACE (City and state or country) TOULON ILL	12. CITIZEN OF WHAT COUNTRY U.S.A.
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13a. FATHER'S NAME WILLIAM H. RIGGS	13b. MOTHER'S MAIDEN NAME ANNA M. ALDEN	14. NAME OF HUSBAND OR WIFE JEWELL D. RIGGS
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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) YES WWII	16. SOCIAL SECURITY NO.	17. INFORMANT VA HSOPITAL RECORDS POPLAR BLUFF, MO. Address
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18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY:		INTERVAL BETWEEN ONSET AND DEATH 1 HOUR
IMMEDIATE CAUSE (a) ACUTE MYOCARDIAL INFARCTION		
CORONARY THROMBOSIS		
Conditions, if any, which gave rise to above cause (e), stating the underlying cause last.	DUE TO (b) ARTERIOSCLEROSIS	

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (e) CEREBRAL ARTERIOSCLEROSIS	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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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.)
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20c. TIME OF INJURY Hour a.m. p.m.	Month, Day, Year
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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
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21. Attended the deceased from VA **Sept 28, 1962** to **Oct 8, 1962** and last saw her alive on _____
Death occurred at **4:55AM** on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <i>Robert S. Cohen</i> (Degree or title) ROBERT S. COHEN M.D. Chief Med Scv.	22b. ADDRESS VA HSOPITAL POPLAR BLUFF, MO.	22c. DATE SIGNED 10-8-62
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23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 10-11-1962	23c. NAME OF CEMETERY OR CREMATORY Applecreek	23d. LOCATION (City, town, or county) Ponahontas Mo.
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24. FUNERAL DIRECTOR Deneke-Laird, Inc. Jackson, Mo.	25. DATE RECD. BY LOCAL REG. 10-10-1962	26. REGISTRAR'S SIGNATURE <i>Thelma Graham</i>
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USE BLACK INK OR TYPEWRITER RIBBON

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 R.O. Laird

Licensed Embalmer No. 4538

P. O. Address Jackson, 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.