

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-63-012514

STATE FILE NUMBER

DO NOT WRITE
ON THIS STUB

AMENDED

Registration District No. 236 Primary Registration District No. 4352 Registrar's No. 22
FILED APR 9 1963

VS 300
Rev. 4/59

1 0710
2 0710₂
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4 1
5 2
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7 0
8 2
9 4200
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12 86-0
13 2-0

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

USE BLACK INK
OR
TYPEWRITER RIBBON

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY MORGAN		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MISSOURI b. COUNTY MORGAN	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN VERSAILLES		Length of stay in 1b 3 WEEKS	
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION KIDWELL REST HOME		d. STREET ADDRESS (If outside, give location) STOVER Mo.	
3. NAME OF DECEASED (Type or print) First LILLIE Middle MABEL Last RIGGS		4. DATE OF DEATH Month APRIL Day 5 Year 1963	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH NOV. 20 1895
9. AGE (last birthday) 67		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY FARM	
11. BIRTHPLACE (City and state or country) HENRY COUNTY Mo.		12. CITIZEN OF WHAT COUNTRY U.S.A.	
13a. FATHER'S NAME JOSEPH BROYLES		13b. MOTHER'S MAIDEN NAME MUNIE K. YORK	
14. NAME OF HUSBAND OR WIFE OSBORN L. RIGGS		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO	
16. SOCIAL SECURITY NO.		17. INFORMANT MRS. FLOSSIE STEWART Address VERSAILLES Mo.	
18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia & decompensation DUE TO (b) Arteriosclerotic heart disease DUE TO (c) 10 yrs Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH 3 days
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Bronchial Asthma			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
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 <input type="checkbox"/> e.m. <input type="checkbox"/> p.m.	Month, Day, Year		
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 bldg., etc.)	20f. CITY, TOWN, OR LOCATION	COUNTY STATE
21. I attended the deceased from 1945 to April 5, 1963 and last saw her alive on Apr 4, 1963 Death occurred at 3:45 p.m. on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) J. Washburn M.D.		22b. ADDRESS Versailles, Mo.	22c. DATE SIGNED 4/6/63
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE APRIL 7 1963	23c. NAME OF CEMETERY OR CREMATORY RITCHIE CEMETERY	23d. LOCATION (City, town, or county) (Specify) MORGAN COUNTY Mo.
24. FUNERAL DIRECTOR Wm. W. Steiner Address Stover Mo.		25. DATE RECD. BY LOCAL REG. 4/6/63	26. REGISTRAR'S SIGNATURE J. Washburn

APR 18 1963

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 J. L. Stevenson

Licensed Embalmer No. 4073

P. O. Address Stouev 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.