

Registration District No. \_\_\_\_\_ Primary Registration District No. 44.08

1. PLACE OF DEATH: 2  
(a) County Pike  
(b) City or town Bowling Green  
(c) Name of hospital or institution: \_\_\_\_\_  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution no  
In this community \_\_\_\_\_  
years, months or days 9

3. (a) PRINT FULL NAME William Denton Riggs  
3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Single

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased Nov. 20 - 1908  
(Month) (Day) (Year)

8. AGE: Years 31 Months 1 Days 15 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace Near Bowling Green Mo.  
(City, town, or county) (State or foreign country)

10. Usual occupation accountant

11. Industry or business \_\_\_\_\_

12. Name J. Claude Riggs

13. Birthplace Near Bowling Green Mo.  
(City, town, or county) (State or foreign country)

14. Maiden name Edna Shoup

15. Birthplace Near Bowling Green Mo.  
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature T. H. Wilcox

(b) Address Bowling Green Mo.

17. (a) \_\_\_\_\_ (b) Date thereof \_\_\_\_\_  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Bowling Green Cem.

18. (a) Signature of funeral director H. B. E. Emore

(b) Address Bowling Green

19. (a) 1-30-1940 (b) H. B. E. Emore  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:  
(a) State Mo (b) County Pike  
(c) City or town Bowling Green  
(If outside city or town limits, write "RURAL")  
(d) Street No. \_\_\_\_\_ (If rural, give location)  
(e) If foreign born, how long in U. S. A. \_\_\_\_\_ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month JANUARY day 5<sup>th</sup>  
year 1940 hour 4 minute 10 P. M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_, 1938, to JAN. 5, 1940

that I last saw him alive on JAN. 5, 1940; and that death occurred on the date and hour stated above.

Immediate cause of death BRAIN TUMOR  
RECURRENCE FOLLOWING OPERATION

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_

Major findings: Of operations INDOLENT  
RECURRENCE BRAIN TUMOR  
Of autopsy \_\_\_\_\_

Duration 3 yrs  
PHYSICIAN \_\_\_\_\_  
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) \_\_\_\_\_

(b) Date of occurrence \_\_\_\_\_

(c) Where did injury occur? \_\_\_\_\_ (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? \_\_\_\_\_

While at work? \_\_\_\_\_ (Specify type of place) (e) Means of injury \_\_\_\_\_

23. Signature W. D. Wilcox (M. D. or other) \_\_\_\_\_

Address Bowling Green Mo. Date signed 1-8-40

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

55A

RECEIVED

District Health Officer No. 10

District File Number 2-40-217

Date Filed FEB 2 1940

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.....

....., Registered Apprentice No.....  
working under my personal supervision.

Signed..... *W. B. E. Moore*

Licensed Embalmer No. 3466

P. O. Address Bowling Green

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 this body is not embalmed, above space should be left blank.

FILL IN ANSWERS TO ALL SPACES  
CHECKED IN RED PENCIL.

MISSOURI STATE BOARD OF HEALTH  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH

3383

Do not use this space.

1. PLACE OF DEATH

(a) County Pike Registration District No. 684  
(b) Township \_\_\_\_\_ Primary Registration District No. 4408 Registered No. \_\_\_\_\_  
(c) City Bowling Green Street No. \_\_\_\_\_ St. \_\_\_\_\_  
(If death occurred in Hospital or Institution, write its name instead of street and number)  
(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME

(a) Residence, No. \_\_\_\_\_ St.  (Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED S (Write the word)

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 1-5- 1940

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF \_\_\_\_\_

22. I HEREBY CERTIFY, That I attended deceased from \_\_\_\_\_ 19\_\_\_\_ to \_\_\_\_\_ 19\_\_\_\_

6. DATE OF BIRTH (MONTH, DAY, AND YEAR)

I last saw h..... alive on \_\_\_\_\_, 19\_\_\_\_. Death is said to have occurred on the date stated above, at \_\_\_\_\_ m.

7. AGE YEARS MONTHS DAYS If LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min. 31 1 15

The principal cause of death and related causes of importance were as follows:

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. \_\_\_\_\_  
9. Industry or business in which work was done, as saw mill, bank, etc. \_\_\_\_\_  
10. Date deceased last worked at this occupation (month and year) \_\_\_\_\_  
11. Total time (years) spent in this occupation \_\_\_\_\_

Brown Tumor Date of onset \_\_\_\_\_  
Recurrente following  
operation 17

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

Other contributory causes of importance:  
Inoperable Recurrence of  
Brown Tumor  
Malignant

13. NAME

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

15. MAIDEN NAME

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

17. INFORMANT (ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL PLACE \_\_\_\_\_ DATE \_\_\_\_\_ 19\_\_\_\_

19. FUNERAL DIRECTOR (ADDRESS)

20. FILED \_\_\_\_\_ 19\_\_\_\_ Local Registrar.

Name of operation \_\_\_\_\_ Date of \_\_\_\_\_  
What test confirmed diagnosis? \_\_\_\_\_ Was there an autopsy? \_\_\_\_\_

23. If death was due to external causes (violence), fill in also the following: Accident, suicide, or homicide? \_\_\_\_\_ Date of injury \_\_\_\_\_ 19\_\_\_\_

Where did injury occur? \_\_\_\_\_ (Specify city or town, county, and State)  
Specify whether injury occurred in industry, in home, or in public place.

Manner of injury \_\_\_\_\_  
Nature of injury \_\_\_\_\_

24. Was disease or injury in any way related to occupation of deceased? \_\_\_\_\_  
If so, specify \_\_\_\_\_

(Signed) W. B. Wilegen, M. D.  
(Address) Bowling Green Mo

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.  
CAUSE OF DEATH IN plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

SUPPLEMENT

5-3383