

FILED MAR 14 1940

Registration District No. \_\_\_\_\_

Primary Registration District No. 5249

Registrar's No. 5

1. PLACE OF DEATH:

(a) County Chariton Missouri  
(b) City or town Rural  
(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 \_\_\_\_\_  
(Specify whether years, months or days)

In this community \_\_\_\_\_  
(Specify whether years, months or days)

3. (a) PRINT FULL NAME DELIA RIGGS 200

3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex Female 5. Color or race Cal 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Ellin Riggs 6. (c) Age of husband or wife if alive 22 years

7. Birth date of deceased April 20 1922  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
17 9 22 hr. min.

9. Birthplace Chariton Co. Mo.  
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business

MOTHER FATHER  
12. Name Johnnie Woods  
13. Birthplace Chariton Co. Mo.  
14. Maiden name Bernanthy Fristo  
15. Birthplace Illinois Mo.

16. (a) Informant Johnnie Woods

(b) Address Gallatin Missouri

17. (a) Ratliff Mo. (b) Date thereof 2 15 1940  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Ratliff Mo.

18. (a) Signature of funeral director R. Maersell

(b) Address Brunswick Mo.

19. (a) Feb. 14 1940 (b) Harry E. Patum  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Chariton

(c) City or town Rural  
(If outside city or town limit, 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 Feb. day 12  
year 1940 hour 5 minute 30 P. M.

21. I hereby certify that I attended the deceased from February 11, 1940, to February 12, 1940  
that I last saw her alive on February 17, 1940  
and that death occurred on the date and hour stated above.

Immediate cause of death \_\_\_\_\_  
Eclampsia

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

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

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

Major findings: \_\_\_\_\_  
Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

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)  
Means of injury \_\_\_\_\_

28. Signature Carl C. Heger (M. D. or other) \_\_\_\_\_

Address Ruffsville Mo. Date signed 2/14/40

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

21

146-

RECEIVED  
District Health Officer No. 8,  
District File Number  
Date Filed 3-11-40

**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.....

Licensed Embalmer No.....

P. O. Address.....

**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.

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. <sup>0</sup> 6279

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Registration District No. ....

Primary Registration District No. ....

Registrar's No. ....

1. PLACE OF DEATH: *Chariton*

(a) County.....

(b) City or town.....  
(If outside city or town limits, write "RURAL" and name of township)

(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.....  
(Specify whether

In this community.....  
years, months or days)

3. (a) PRINT FULL NAME *Debra Riggs*

3. (b) If veteran, name war.....

(c) Social Security No. ....

4. Sex *F* 5. Color or race *B*

6. (a) Single, widowed, married, divorced *m*

6. (b) Name of husband or wife.....

6. (c) Age of husband, or wife, if alive..... years

7. Birth date of deceased.....  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day

*17* hr. min.

9. Birthplace.....  
(City, town, or county) (State or foreign country)

10. Usual occupation.....

11. Industry or business.....

MOTHER FATHER { 12. Name.....

13. Birthplace.....  
(City, town, or county) (State or foreign country)

14. Maiden name.....

15. Birthplace.....  
(City, town, or county) (State or foreign country)

16. (a) Informant.....

(b) Address.....

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

(c) Place: burial or cremation.....

18. (a) Signature of funeral director.....

(b) Address.....

19. (a) (b).....  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State..... (b) County.....

(c) City or town.....  
(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.

19. MEDICAL CERTIFICATION

20. DATE OF DEATH Month *Feb.* Day *17* - Year *40*

year..... hour..... minute..... M.

21. I hereby certify that I attended the deceased from....., 19....., to....., 19.....;

that I last saw him..... alive on....., 19.....,

and that death occurred on the date and hour stated above.

Immediate cause of death *Eclampsia*

Due to *postpartum*

Due to *high "granny" blood*

*inable baby about 22 hours before death.*

Other conditions.....  
(Include pregnancy within 3 months of death)

Major findings: Of operations.....

Of autopsy.....

Duration

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 *Carl C. Wager* (M. D. or other)

Address *Kepler ville, Mo.* Date signed.....

SUPPLEMENTARY

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

Am

