

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

Registration District No. 1012

Primary Registration District No. 5480

1. PLACE OF DEATH:

(a) County Harrison
(b) City or town McFall Rural Butler
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Home
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____
(Specify whether _____)
In this community 80 yrs
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Harrison
(c) City or town McFall Rural
(If outside city or town limits, write "RURAL")
(d) Street No. Harrison to Butler Turn
(If rural, give location)
(e) If foreign born, how long in U. S. A? _____ years.

3. (a) PRINT FULL NAME DAVID RIGGINS

3. (b) If veteran, name war r 3. (c) Social Security No. ✓

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

6. (b) Name of husband or wife Cornelia Riggins 6. (c) Age of husband or wife if alive 82 years

7. Birth date of deceased Oct 23 1853
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>86</u>	<u>5</u>		hr. _____ min.

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

10. Usual occupation Farmer

MOTHER FATHER

11. Industry or business ✓

12. Name William Riggins

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

14. Maiden name Betsy Hains

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

16. (a) Informant's own signature Lucret Riggins
(b) Address McFall Mo

17. (a) _____ (b) Date thereof 3 25 1940
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Jones Chapel

18. (a) Signature of funeral director W H Noble
(b) Address Newt's Capital Mo

19. (c) April 26 1940 (b) Mrs. Watson Reed
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Mar day 13
year 1940 hour 11 minute 5 P.M.

21. I hereby certify that I attended the deceased from 3-23-40
19____ to 3-23- 1940;
that I last saw him alive on March 23 1940;
and that death occurred on the date and hour stated above.

Immediate cause of death Lobar Pneumonia Duration 2 days

Due to Grippe 1 wk.

Due to 118

Other conditions Hemiplegia 5 yrs
(Include pregnancy within 3 months of death)
due to Arterial Hypertension PHYSICIAN _____

Major findings: _____
Of operations _____
Of autopsy _____
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? 3H
While at work? _____ (Specify type of place)
(e) Means of injury _____

23. Signature Frank N. Roe (M. D. or other)
Address Albany, Mo Date signed 3-23-40

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

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.

RECEIVED

District Health Officer No. 111

District File Number 340-788

Date Filed MAY 15 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 me

W G Noble, Registered Apprentice No. _____
working under my personal supervision.

Signed W G Noble

Licensed Embalmer No. 2904

P. O. Address New Hampton 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 this body is not embalmed, above space should be left blank.