

S. No. 2
1-11-10-39
v. 5-17-39
I X21492

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **27523**
Registrar's No. **3156**

SEP 5 1940 399
Registration District No. _____

Primary Registration District No. **1002**

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

1. PLACE OF DEATH:

(a) County **Jackson**
(b) City or town **Kansas City**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
K.C. General Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **2hrs.**
(Specify whether
In this community **--**
years, months or days)

3. (a) PRINT FULL NAME **Riggs infant**
3. (b) If veteran, name war **----**
3. (c) Social Security No. **----**

4. Sex **Female**
5. Color or race **W.**
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 **July 13th 1940**
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
-- -- -- 2 hr. min.

9. Birthplace: **K.C. Mo.**
(City, town, or county) (State or foreign country)

10. Usual occupation **infant**

11. Industry or business
12. Name **Robert Riggs**
13. Birthplace **Mass.**
(City, town, or county) (State or foreign country)
14. Maiden name **Krisnor Crouch**
15. Birthplace **Ohio**
(City, town, or county) (State or foreign country)

16. (a) Informant **Record clerk**
(b) Address **K.C. Gen. Hosp.**

17. (a) **Burial** (b) Date thereof **8-8-40**
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation **Leeds Municipal Cem.**

18. (a) Signature of funeral director **W.A. Lohmeyer**
(b) Address **City mortician**

19. (a) **Aug. 7, 1940** (b) **M. M. Brown**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Jackson**
(c) City or town **Kansas City**
(If outside city or town limits write "RURAL")
(d) Street No. **1808 Mercier**
(If rural, give location)
(e) If foreign born, how long in U. S. A. ? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **July** day **13th**
year **1940** hour **5** minute **30 A.** M.

21. I hereby certify that I attended the deceased from **7-13-40** to **7-13-40**, 19____, to
that I last saw her alive on **7-13-40**, 19____,
and that death occurred on the date and hour stated above.

Immediate cause of death **Prematurity**
Duration _____

Due to _____
Due to _____
Other conditions (Include pregnancy within 3 months of death) _____

PHYSICIAN
Major findings: _____
Of operations _____
Of autopsy **See above**
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? _____

(Specify type of place)
While at work? _____ (c) Means of injury **1**
23. Signature **Dr. R. Shon** (M. D. or other)
Med. Dir. K.C. Gen. Hospital
Address _____ Date signed _____

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.