

FILED NOV 3 1944
Registration District No. 2

Primary Registration District No. 1005

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

1. PLACE OF DEATH:

(a) County Buchanan

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

(c) Name of hospital or institution:
716 W 6th St 1
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution no (Specify whether)

In this community _____ years, months or days

3. (a) PRINT FULL NAME James W. Riggs

3. (b) If veteran, name war No

3. (c) Social Security No. _____

4. Sex Male 5. Color or race White

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

6. (b) Name of husband or wife _____

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

7. Birth date of deceased Oct 13 1876
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
<u>67</u>			hr. _____ min. _____

9. Birthplace Plattsmouth, Ray County, Mo
(City, town, or county) (State or foreign country)

10. Usual occupation Rubber

MOTHER FATHER

11. Industry or business _____

12. Name unknown

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

14. Maiden name unknown

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

16. (a) Informant Social Security Records

(b) Address Patel Hall St Joseph Mo

17. (a) Burial (b) Date thereof 10-30-44
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Memorial Park Cemetery

18. (a) Signature of funeral director Barry Funeral Home

(b) Address 224 South 10th St St Joseph Mo

19. (a) 10-30-44 (b) Eden J. Chelle
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Buchanan

(c) City or town St Joseph
(If outside city or town limits, write "RURAL")

(d) Street No. _____ (If rural, give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct day 27
year 1944 hour 6 minute A M.

21. I hereby certify that I attended the deceased from Sept 25
1944 to Oct 23 1944
that I last saw him alive on Oct 23 1944
and that death occurred on the date and hour stated above.

Immediate cause of death Coronary myocarditis
myocardial degeneration

Due to Coronary myocarditis 1944
myocardial degeneration Oct 23 1944

Due to Arteriosclerosis 5 yrs

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

PHYSICIAN

Major findings: ASD

Of operations ASD

Of autopsy ASD

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)

(c) Means of injury ✓

23. Signature Charles W. Kennel (M. D. or other)

Address 321 Kirkwood Ave Date signed 10-28-44

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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 *Mollie E. Sidenfaden Fox*
Licensed Embalmer No. *4235*
P. O. Address *St. Joseph, 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, fact should be so stated above.