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5-17-39  
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DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **21131**

**FILED JUL 15 1946**

Registration District No. **278**

Primary Registration District No. **4412**

Registrar's No. \_\_\_\_\_

**1. PLACE OF DEATH:**

(a) County Pike

(b) City or town Frankford  
(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 10 years  
years, months or days

**2. USUAL RESIDENCE OF DECEASED:**

(a) State Missouri (b) County Pike

(c) City or town Frankford, Rural  
(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: \_\_\_\_\_

**3. (a) PRINT FULL NAME** CORILLA JANE RIGGS

3. (b) If veteran, name war: \_\_\_\_\_

3. (c) Social Security No. \_\_\_\_\_

4. Sex F

5. Color or race W

6. (a) Single, widowed, married, divorced 1

6. (b) Name of husband or wife: J. W. Riggs

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

7. Birth date of deceased June 27 1946  
(Month) (Day) (Year)

**8. AGE:** Years 62 Months 10 Days 17  
If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

**9. Birthplace** Pike Co. Missouri  
(City, town, or county) (State or foreign country)

**10. Usual occupation** Housewife

**11. Industry or business**

12. Name William McCune

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

14. Maiden name Cynthia Morgan

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

**16. (a) Informant** J. W. Riggs

(b) Address Frankford Mo

**17. (a) Burial** (b) Date thereof May 16 46  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Frankford Mo

**18. (a) Signature of funeral director** J. H. Fields & Son

(b) Address Frankford Mo

**19. (a) June 13/46** (b) August B. Stephens  
(Date received local registrar) (Registrar's signature)

**MEDICAL CERTIFICATION**

**20. DATE OF DEATH:** Month May day 14 Th. year 1946 hour 4 minute 30 A.M.

**21. I hereby certify that I attended the deceased from** March 1946 to May 1946  
that I last saw her alive on May 12 and that death occurred on the date and hour stated above.

Immediate cause of death Heart Failure Duration \_\_\_\_\_

Due to hypertension & stroke of apoplexy

Due to Paralysis

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

**Major findings:**

Of operations \_\_\_\_\_

Of autopsy 830

**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? \_\_\_\_\_

(Specify type of place) \_\_\_\_\_

While at work? \_\_\_\_\_ (e) Means of injury 2

**23. Signature** E. P. Hansen (M. D. or other) D.P.

Address Frankford Mo Date signed 5/16/46

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

MOTHER FATHER

RECEIVED

District Health Officer No. 10

District File Number 7-46-1255

Date Filed JUL 12 1946

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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

*Irene Fields Megaw*

Licensed Embalmer No.

*4093*

P. O. Address

*Frankford, Md*

**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.