

National Office of Vital Statistics

State File No. ....

FILED NOV 4 1947

4442

Registration District No. ....

Primary Registration District No. 1002

Registrar's No. ....

## 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 General Hospital No. 1  
 (If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution 1 1/2 days  
 (Specify whether  
 In this community All his life  
 years, months or days)

3. (a) PRINT  
FULL NAMEGeorge Riggs3. (b) If veteran,  
name war NO

3. (c) Social Security No.

486-26-6766

4. Sex M 5. Color or race W 6. (a) Single, widowed, married,  
divorced Single  
 6. (b) Name of husband or wife Single 6. (c) Age of husband or wife if  
alive 42 years  
 7. Birth date of deceased 4 2 1887  
 (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
60 6 21 hr. min.

9. Birthplace Missouri  
(City, town, or county) (State or foreign country)10. Usual occupation Watchman

11. Industry or business

12. Name Geo. W. Riggs13. Birthplace Mo. V  
(City, town, or county) (State or foreign country)14. Maiden name Jean Foster15. Birthplace Mo. W  
(City, town, or county) (State or foreign country)16. (a) Informant Charlie G. Riggs(b) Address 1901 Eastern R. C. Kans.17. (a) Elmwood (b) Date thereof 10/25/47  
(Burial, cremation, or removal) (Month) (Day) (Year)(c) Place: burial or cremation Elmwood Cemetery18. (a) Signature of funeral director Stone & McClure(b) Address 3235 Wilham Plaza, S. P. Mo.19. (a) 10-24-47 (b) Heraldine Holmes  
(Date received local registrar) (Registrar's signature)

## 2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson 4/8  
 (c) City or town Kansas City 3  
 (If outside city or town limits, write "RURAL")  
 (d) Street No. 5907 E 32 St. 8  
 (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 23  
 year 1947 hour 1 minute 5 A. M.

21. I hereby certify that I attended the deceased from Oct. 21 1947 to Oct. 23 1947  
 that I last saw him im alive on Oct. 23 1947  
 and that death occurred on the date and hour stated above.

Immediate cause of death:  
Arteriosclerotic and rheumatic  
heart disease-Congestive heart  
failure and cerebral edema-  
Intestinal hemorrhage

Due to.....

Other conditions  
(Include pregnancy within 3 months of death)Major findings:  
Of operations.....Of autopsy See above

## 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 023. Signature 20-25-47 (M. D. or other) 20-25-47Address Med. Dir. Gen'l Hosp. Date signed 10-23-47

*Dr. Johnson*

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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 *Robert H Reed*

Licensed Embalmer No. *2745*

P. O. Address *K C W*

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.

Registration District No. 149

Primary Registration District No. 1002

Registrar's No. 4442

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:  
(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

George Riggs

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

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

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 hr. \_\_\_\_\_ min. \_\_\_\_\_

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

10. Usual occupation \_\_\_\_\_

11. Industry or business \_\_\_\_\_

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) 10-24-47 Heraldine Holmes  
(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) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
 If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct day 25  
 year 1947 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_ 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: arteriosclerotic & rheumatic heart disease

Due to congestive heart failure & cerebral edema

Due to intestinal hemorrhage, digitalis intoxication with gastritis and

Other conditions: enteritis  
(Include pregnancy within 3 months of death)

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

Of autopsy see above

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 Wm. W. Hart (M. D. or other) \_\_\_\_\_  
 Address Sen. Chap. #1 Date signed \_\_\_\_\_

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

SUPPLEMENTARY

S-34646