

FILED MAY 6 1954
Columer

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 14009
3882

BIRTH NO. _____ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. _____

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|---------------------------------------------------------------------------------------------------------|---------------------------|------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------|-----------------------------------------------------------------------------|------------------------------------------------------------------------|
| 1. PLACE OF DEATH a. COUNTY | | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri. b. COUNTY | | | |
| b. CITY (If outside corporate limits, write RURAL and give town or township) St. Louis, Mo. | | c. LENGTH OF STAY (In this place) | | c. CITY OR TOWN St. Louis, | |
| d. FULL NAME OF HOSPITAL OR INSTITUTION City Hospital. | | 10. STREET ADDRESS (If rural, give location) 19 3740 Westminster 21990 | | | |
| 3. NAME OF DECEASED (Type or Print) a. (First) George b. (Middle) Garland c. (Last) Riggan | | | 4. DATE OF DEATH (Month) (Day) (Year) Apr. 26, 1954. | | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) never married | 8. DATE OF BIRTH June, 25, 1883 | 9. AGE (In years last birthday) 70 | IF UNDER 1 YEAR Months IF UNDER 24 HRS. Days Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Minister | | 10b. KIND OF BUSINESS OR INDUSTRY Ministry | | 11. BIRTHPLACE (City and State or Foreign Country) Louisville, Kentucky, | |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | 13a. FATHER'S NAME Unknown | | 13b. MOTHER'S MAIDEN NAME Unknown | |
| 14. NAME OF HUSBAND OR WIFE never married, | | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No Nil. | | 16. SOCIAL SECURITY NO. 493-24-4529 | |
| 17. INFORMANT'S SIGNATURE OR NAME Thomas M. Brady, Civil Cts Bldg. | | ADDRESS | | | |

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|----------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------|--|--|----------------------------------|
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) | | MEDICAL CERTIFICATION | | | INTERVAL BETWEEN ONSET AND DEATH |
| I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) | | Pneumonia | | | |
| *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death. | | DUPLICATE (b) Carotid Occlusion | | | |
| II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. | | | | | |

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|-------------------------------------------------------|--------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------|
| 19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT SUICIDE HOMICIDE (Specify) | 21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) 4201 |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min) | 21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | 21f. HOW DID INJURY OCCUR? |

22. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at 5:05 PM., from the causes and on the date stated above.

| | | | |
|------------------------------------------------------|----------------------------------------|------------------------------------------------------------------------------|------------------------------------------------------------------------|
| 22a. SIGNATURE Patrick C. Taylor Carauer | (Degree or title) | 22b. ADDRESS 1300 Clark | 22c. DATE SIGNED 4-29-54 |
| 24a. BURIAL, CREMATION, REMOVAL (Specify) Removal | 24b. DATE May 1, 1954 | 24c. NAME OF CEMETERY OR CREMATORY Memorial Pk Cemetery | 24d. LOCATION (City, town, or county) (State) St. Louis, County Mo. |
| DATE REC'D BY LOCAL REG. APR 29 1954 | REGISTRAR'S SIGNATURE J. Earl Smith | 25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Albert H. Hoppe 4700 Washington. | |

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

1951 AUG 1

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~~, Student Embalmer No..... working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed.....
Elton R. Remelius

Licensed Embalmer No. 728

P. O. Address.....
St. Louis

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.