Health, Welfare Public Service

300 -57

FILED OCT 4 1957

THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

STATE FILE NUMBER 34041 9050

Registration District No. 318 Primary Registration District No. 1003 Registrar's No.

1. PLACE OF DEATH
a. COUNTY St. Louis
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis, Missouri — Inside Limits Yes ☒ No ☐
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Mupac Hospital — Length of stay in Ib

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Missouri b. COUNTY
c. CITY OR TOWN St. Louis — Inside Limits Yes ☒ No ☐
d. STREET ADDRESS (If outside, give location) 4585 Garfield — Reside on Farm Yes ☐ No ☒

3. NAME OF DECEASED (Type or print) First Charles Middle Callie Last Riggs
4. DATE OF DEATH Month Sept. Day 25 Year 1957
5. SEX M
6. COLOR OR RACE C
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH 8/24/1874
9. AGE (In years last birthday) 83 — IF UNDER 1 YEAR Months 1 Days 1 — IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Engine Watchman retired
10b. KIND OF BUSINESS OR INDUSTRY R.R.
11. BIRTHPLACE (City and state or country) Mississippi
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13a. FATHER'S NAME Granville Riggs
13b. MOTHER'S MAIDEN NAME Unknown
14. NAME OF HUSBAND OR WIFE Cora Riggs
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service) none
16. SOCIAL SECURITY NO. —
17. INFORMANT Cora Riggs Address 4585 Garfield

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) — INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cerebrovascular Accident — 2
Terminal Pneumonia
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Generalized Arteriosclerosis
DUE TO (c) 331k

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a). Fibrous Pleurisy

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year
20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
20f. CITY, TOWN, OR LOCATION COUNTY STATE

21. I attended the deceased from Sept. 16, 1957 to Sept. 25, 1957 and last saw her/him alive on Sept. 25, 1957
Death occurred at 11:15 P. m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE Charles Thomas M.D. (Degree or title)
22b. ADDRESS 1755 S. Grand
22c. DATE SIGNED 9-27-57

23a. BURIAL, CREMATION, REMOVAL (Specify) Removal
23b. DATE 9/30/57
23c. NAME OF CEMETERY OR CREMATORY
23d. LOCATION (City, town, or county) (State) Evansville, Indiana

24. FUNERAL DIRECTOR Charles J. Gates ADDRESS 4107 Finney
25. DATE RECD. BY LOCAL REG. SEP 28 57
26. REGISTRAR'S SIGNATURE J. Earl Smith, M.D. S.P.

(Licensed Embalmer's Statement on Reverse Side)

All diseases in Part I must be causally related. USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

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 Guyton Green

Licensed Embalmer No. 4580

P. O. Address 4107 Finney

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.