

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS AUG 26 1959

59-029730

Registration District No. 187 Primary Registration District No. 3040 Registrar's No. 215

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <u>Livingston</u>				2. USUAL RESIDENCE (Where deceased lived. If institutional Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>Caldwell</u>									
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Chillicothe</u>		Length of stay in 1b <u>10 months</u>		c. CITY OR TOWN <u>Cowgill</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>							
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Chillicothe hospital</u>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>Davis Twp.</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) First <u>PEARL</u> Middle <u>RIGGS</u> Last <u>RIGGS</u>				4. DATE OF DEATH Month <u>August</u> Day <u>15</u> Year <u>1959</u>									
5. SEX <u>female</u>		6. COLOR OR RACE <u>white</u>		7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <u>5/14/1875</u>		9. AGE (last birthday) <u>84</u>		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		IF UNDER 24 HR Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>retired</u>		11. BIRTHPLACE (City and state or country) <u>Missouri</u>		12. CITIZEN OF WHAT COUNTRY <u>U. S. A.</u>					
13a. FATHER'S NAME <u>Jasper N. Rodgers</u>				13b. MOTHER'S MAIDEN NAME <u>Rebecca Price</u>				14. NAME OF HUSBAND OR WIFE <u>Orin Riggs</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>				16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT <u>Fred Wightman, Braymer, Mo.</u> Address <u> </u>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Chr. Myocarditis.</u>										INTERVAL BETWEEN ONSET AND DEATH			
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u> </u>													
DUE TO (c) <u> </u>													
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Intestines fractured left femur Nov 2, 1958</u>								PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown					
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT <input checked="" type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) <u>Fall on premises of home</u>									
20c. TIME OF INJURY Hour <u>2:00</u> a.m. <u> </u> p.m. <u> </u> Month, Day, Year <u>Nov 2, 1958</u>		20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>Home</u>		20f. CITY, TOWN, OR LOCATION <u>Cowgill</u>		COUNTY <u>Caldwell</u>		STATE <u>Mo</u>			
21. I attended the deceased from <u>Nov 2, 1958</u> to <u>Aug 15, 1959</u> and last saw her alive on <u>Aug 14, 1959</u> Death occurred at <u>7:50 a.m.</u> on the date stated above, and to the best of my knowledge from the causes stated.													
22a. SIGNATURE (Degree or title) <u>M. A. Dowell, M.A.</u>						22b. ADDRESS <u>Chillicothe MO</u>			22c. DATE SIGNED <u>8/20/59</u> (State)				
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		23b. DATE <u>8/17/1959</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Evergreen cemetery</u>			23d. LOCATION (City, town, or county) <u>Braymer, Mo.</u>						
24. FUNERAL DIRECTOR <u>Michael Funeral Home, Braymer, Mo.</u>				25. DATE RECD. BY LOCAL REG. <u>8/20/59</u>		26. REGISTRAR'S SIGNATURE <u>Frances B Hall</u>							

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by

or by _____, Student Embalmer No. _____

~~working under my personal supervision.~~

Student _____

Signature of Student Embalmer

Signed Geneb. Michael

Licensed Embalmer No. 4340

P. O. Address Braymer, 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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.