

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=60-002530

FILED VS. FEB. 5 1960 209

Primary Registration District No. 3043 Registrar's No. 38

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <b>Marion</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Mo</b> b. COUNTY <b>Rolla,</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Hannibal, Missouri.</b>		c. CITY OR TOWN <b>Center, Missouri.</b>	
Length of stay in 1b <b>30Dys</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Lovering Hospital</b>		d. STREET ADDRESS (If outside, give location) <b>Center, Mo.</b>	
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First <b>ABBIE</b> Middle <b>R.</b> Last <b>RIGGS</b>			4. DATE OF DEATH Month <b>Jan</b> Day <b>20,</b> Year <b>1960</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>11-6-78</b>	9. AGE (last birthday) <b>81</b>	IF UNDER 1 YEAR IF UNDER 24 HR Months Days Hours Min.	

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housework</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>	11. BIRTHPLACE (City and state or country) <b>Kentucky.</b>	12. CITIZEN OF WHAT COUNTRY <b>USA</b>
13a. FATHER'S NAME <b>Unknown</b>	13b. MOTHER'S MAIDEN NAME <b>Unknown.</b>	14. NAME OF HUSBAND OR WIFE <b>Wm M. Riggs</b>	

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>	16. SOCIAL SECURITY NO. <b>None.</b>	17. INFORMANT Address <b>Mrs Cathelene Scobee Hannibal, Mo.</b>
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral thrombosis, generalized arteriosclerosis</b>		INTERVAL BETWEEN ONSET AND DEATH <b>5 weeks</b>
DUE TO (b) _____		
DUE TO (c) _____		

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)	PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> N. <input type="checkbox"/> Unknown
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19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input 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.)
20c. TIME OF INJURY Hour _____ a.m. _____ p.m.	Month, Day, Year _____	

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.)	20f. CITY, TOWN, OR LOCATION COUNTY STATE
21. I attended the deceased from <b>12/19/59</b> to <b>1/20/60</b> and last saw her/him alive on <b>1/19/60</b>		
Death occurred at <b>11:30 A.m</b> on the date stated above, and to the best of my knowledge, from the causes stated.		

22a. SIGNATURE <b>M. Scobee</b> (Degree or title) <b>M.D.</b>	22b. ADDRESS <b>Hannibal, Mo.</b>	22c. DATE SIGNED <b>1-22-60</b>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>1-22-60</b>	23c. NAME OF CEMETERY OR CREMATORY <b>MtPrarie Cemotery.</b>	23d. LOCATION (City, town, or county) (State) <b>Monroe Co, Mo.</b>
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24. FUNERAL DIRECTOR ADDRESS <b>Clyde Wilcox Perry, Mo.</b>	25. DATE RECD. BY LOCAL REG. <b>2/2/60</b>	26. REGISTRAR'S SIGNATURE <b>Dr. E. M. Lucke by Lillian M. Herman</b>
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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 Clyde B. Weckert

Licensed Embalmer No. 382

P. O. Address Perry, 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.