

WRITE PLAINLY, WITH CARE

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

PLACE OF DEATH
County Pettis
Township Hughesville
or
Village _____
or
City _____ (NO. _____ St. _____ Ward _____)

Registration District No. 646 File No. 20163
Primary Registration District No. 5887 Registered No. 11

(If death occurred in a hospital or institution, give its NAME instead of street and number)

FULL NAME Robert William Riley

PERSONAL AND STATISTICAL PARTICULARS		
SEX <u>M</u>	COLOR OR RACE <u>W</u>	SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) <u>married</u>
DATE OF BIRTH <u>Feb.</u> <u>16</u> , 19 <u>14</u> (Month) (Day) (Year)		
AGE <u>28</u> yrs. <u>3</u> mos. <u>29</u> ds. If LESS than 1 day, hrs. or min.?		
OCCUPATION (a) Trade, profession, or particular kind of work <u>Farming</u> (b) General nature of industry, business, or establishment in which employed (or employer) <u>52</u>		
BIRTHPLACE (City or town, State or foreign country) <u>Pennsylvania</u> <u>101</u>		
PARENTS	NAME OF FATHER <u>James Riley</u>	
	BIRTHPLACE OF FATHER (City or town, State or foreign country) <u>Pennsylvania</u>	
	MAIDEN NAME OF MOTHER <u>Martha Nelson</u>	
	BIRTHPLACE OF MOTHER (City or town, State or foreign country) <u>Pennsylvania</u>	

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) _____
(ADDRESS) _____

Filed June 15, 1914 W. T. Bishop
REGISTRAR

MEDICAL CERTIFICATE OF DEATH	
DATE OF DEATH <u>June 15</u> , 19 <u>14</u> (Month) (Day) (Year)	I HEREBY CERTIFY, that I attended deceased from <u>May 25</u> , 19 <u>14</u> , to <u>June 15</u> , 19 <u>14</u> , that I last saw him alive on <u>June 15</u> , 19 <u>14</u> , and that death occurred, on the date stated above, at <u>5:30</u> p.m.
The CAUSE OF DEATH* was as follows: <u>Epithelioma of the face</u>	
(Duration) <u>4</u> yrs. _____ mos. _____ ds.	
Contributory <u>Pneumonia</u> (SECONDARY) (Duration) _____ yrs. _____ mos. _____ ds.	
(Signed) <u>W. T. Bishop</u> M. D. June <u>16</u> , 19 <u>14</u> (Address) <u>Hughesville</u>	
*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.	
LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.	
Where was disease contracted if not at place of death? Former or usual residence _____	
PLACE OF BURIAL OR REMOVAL <u>Sidalia Mo</u>	DATE OF BURIAL <u>June 17</u> , 19 <u>14</u>
UNDERTAKER <u>McLaughlin Bros Sidalia Mo</u>	ADDRESS

PLACE OF DEATH

County _____

Township _____

or _____

Village _____

or _____

City _____

Registration District No. _____

File No. _____

Primary Registration District No. _____

Registered No. _____

(NO. _____)

St. _____

Ward _____

If death occurred
hospital or instit.
give its NAME in
of street and number

FULL NAME

PERSONAL AND STATISTICAL PARTICULARS

SEX	COLOR OR RACE	SINGLE MARRIED WIDOWED OR DIVORCED (If file the word)
DATE OF BIRTH		
(Month) _____ (Day) _____ (Year) _____		
AGE		If LESS than 1 day, _____ hrs. or _____ min.?
OCCUPATION		_____ yrs. _____ mos. _____ ds.
(a) Trade, profession, or particular kind of work		
(b) General nature of industry, business, or establishment in which employed (or employer)		

BIRTHPLACE

(City or town, State or foreign country)

NAME OF FATHER

(City or town, State or foreign country)

BIRTHPLACE OF FATHER

(City or town, State or foreign country)

MAIDEN NAME OF MOTHER

BIRTHPLACE OF MOTHER

(City or town, State or foreign country)

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) _____

(ADDRESS) _____

Filed _____

191 _____

REGISTRAR

Missouri State Board of Health

Bureau of Vital Statistics

Certificate of Death

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH

(Month) _____ (Day) _____ (Year) _____

I HEREBY CERTIFY, that I attended deceased

_____ 191 _____, to _____ 19 _____,

that I last saw h _____ alive on _____ 19 _____,

and that death occurred, on the date stated above, at _____

The CAUSE OF DEATH was as follows:

(Duration) _____ yrs. _____ mos.

Contributory

(SECONDARY)

(Duration) _____ yrs. _____ mos.

(Signed) _____

(Address) _____

*State the Disease Causing Death, or, in deaths from Violent Causes, (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (FOR HOSPITALS INSTITUTIONS, TRANSIENT RECENT RESIDENTS)

At place of death _____ yrs. _____ mos. _____ ds. State _____ yrs. _____ mos.

Where was disease contracted if not at place of death?

Former or usual residence _____

PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

UNDERTAKER

ADDRESS