

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

Do not use this space.

13857

PLACE OF DEATH
 Copy to _____
 Townshp. Carroll
 City _____ (No. _____) St. _____ (Ward _____)

Registration District No. 49
 Primary Registration District No. 5116

File No. _____
 Registered No. _____

2. FULL NAME Alameda Riley
 (a) Residence No. _____ St. _____ Ward _____
 (Usual place of abode)
 Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.
 (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female | **4. COLOR OR RACE** White | **5. SINGLE, MARRIED, WIDOWED OR DIVORCED** (write the word) Widowed

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR) June 23-1842

7. AGE
 YEARS MONTHS DAYS | If LESS than 1 day, hrs. or min.
86 | 9 | 20.

8. OCCUPATION OF DECEASED
 (a) Trade, profession, or particular kind of work Retired
 (b) General nature of industry, business, or establishment in which employed (or employer)
 (c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Mo.

10. NAME OF FATHER Sam McCaskey

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) Scotland

12. MAIDEN NAME OF MOTHER Lindie Lewis

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) Mo.

14. INFORMANT (Address) C. M. Bradley
Class Mo.

15. FILED 4/14/1929 E. N. Gentry REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Apr. 13 - 1929

17. I HEREBY CERTIFY, That I attended deceased from On March 6 - 1929, to I saw her only the once that I last saw her alive on March 6 - 1929, and that death occurred, on the date stated above, at About 8 A.M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Gangrene of Left Foot

CONTRIBUTORY (SECONDARY) Probably from injury to the foot
 (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED
 IF NOT AT PLACE OF DEATH, _____

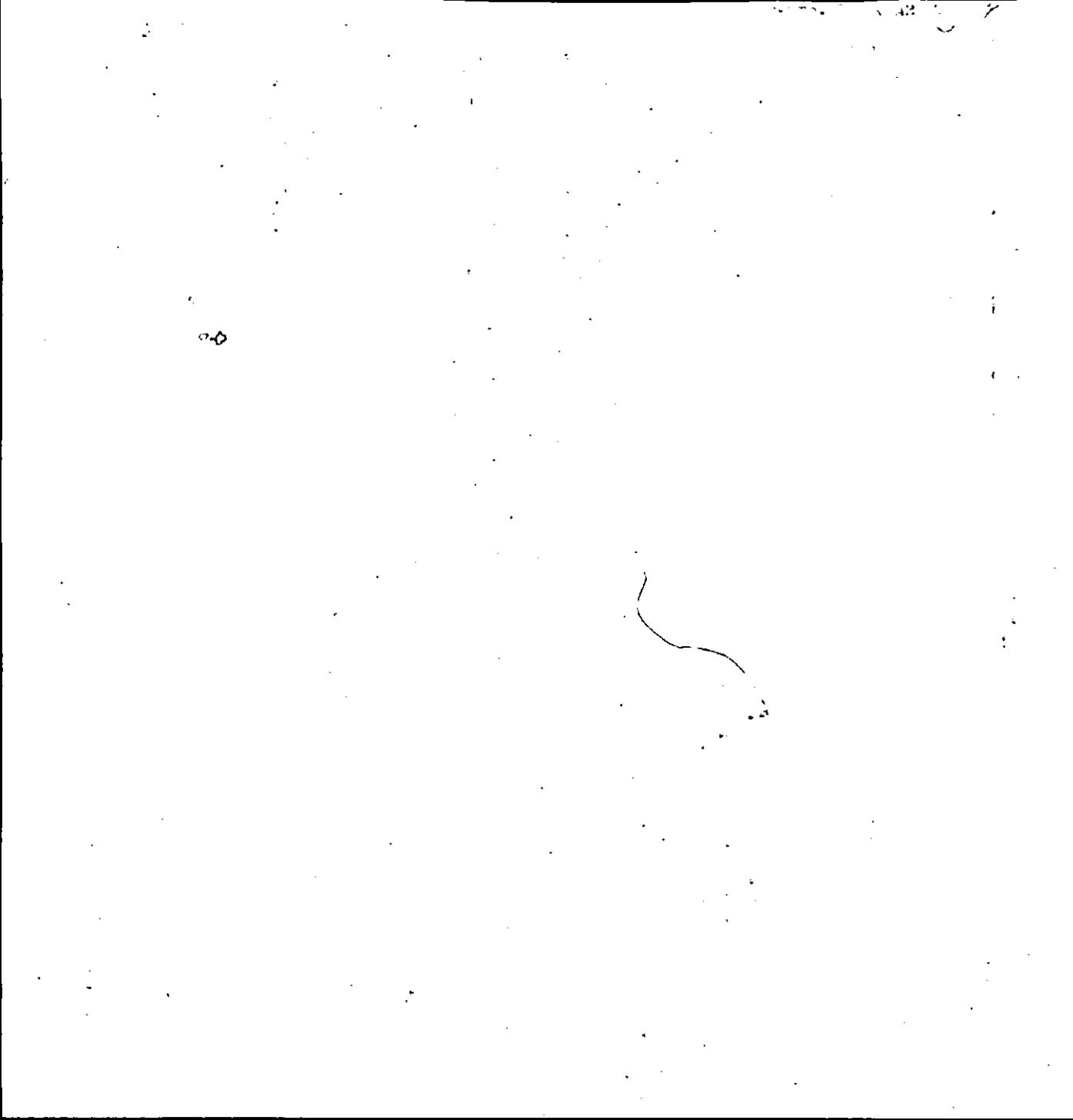
19. DID AN OPERATION PRECEDE DEATH? No. DATE OF _____
 WAS THERE AN AUTOPSY? No.

WHAT TEST CONFIRMED DIAGNOSIS? General observation
 (Signed) E. N. Gentry, M. D.
 , 19 (Address) Sturgeon J. Mo.

*State the DISEASE CAUSING DEATH, OR IN DEATHS FROM VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Union Cem. | **DATE OF BURIAL** 4/14/1929

20. UNDERTAKER Barnes F. W. Co. | **ADDRESS** Sturgeon J. Mo.



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ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH
 County Boone Registration District No. 79 File No. _____
 Township Bourbon Primary Registration District No. 5-116 Registered No. 14
 City _____ (No. _____) St. _____ Ward _____

2. FULL NAME Alameda Riley
 (a) Residence. No. _____ St. _____ Ward _____
 (Usual place of abode) (If nonresident, give city or town and State)
 Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) wid

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF _____

6. DATE OF BIRTH (MONTH, DAY AND YEAR) _____

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.

8. OCCUPATION OF DECEASED

- (a) Trade, profession, or particular kind of work _____
 (b) General nature of industry, business, or establishment in which employed (or employer) _____
 (c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN) _____
 (STATE OR COUNTRY) _____

10. NAME OF FATHER _____
 11. BIRTHPLACE OF FATHER (CITY OR TOWN) _____
 (STATE OR COUNTRY) _____
 12. MAIDEN NAME OF MOTHER _____
 13. BIRTHPLACE OF MOTHER (CITY OR TOWN) _____
 (STATE OR COUNTRY) _____

14. INFORMANT _____
 (Address) _____

15. FILED 6/10/29 E. N. Gentry REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Sept 13 1929

17. I HEREBY CERTIFY That I attended deceased from _____ 19____ to _____ 19____ that I last saw h. _____ alive on _____, 19____, and that death occurred, on the date stated above, at _____ m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Gangrene of left foot
Unknown (duration) _____ yrs. mos. ds.
 CONTRIBUTORY (SECONDARY) Possibly from
injury to the foot (duration) _____ yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED _____
 IF NOT AT PLACE OF DEATH _____
 DID AN OPERATION PRECEDE DEATH? _____ DATE OF _____
 WAS THERE AN AUTOPSY? _____
 WHAT TEST CONFIRMED DIAGNOSIS? _____
 (Signed) _____, M. D.
 , 19____ (Address) _____

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) Whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL _____ DATE OF BURIAL _____ 19____

20. UNDERTAKER _____ ADDRESS _____

SUPPLEMENTARY

REG. I. LL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

S-13857