

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

Do not use this space.

39340

1. PLACE OF DEATH
 County Schuyler Registration District No. 806
 Township _____ Primary Registration District No. 4450
 City Queen City (No. _____) St. _____ Ward _____

2. FULL NAME William Ernest 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 male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) _____

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Nov 28 - 29

7. AGE YEARS MONTHS DAYS If LESS than 1 day, 3 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) Queen City Mo
 (STATE OR COUNTRY)

10. NAME OF FATHER Ernest Robert Riley

11. BIRTHPLACE OF FATHER (CITY OR TOWN) Queen City Mo
 (STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER Emma Teledia Myers

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

14. INFORMANT Ernest R Riley
 (Address) Queen City Mo

15. FILED _____ 19 _____ REGISTRAR J. H. Jones

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Nov 28 1929

17. I HEREBY CERTIFY, That I attended deceased from Nov 28, 1929, to Nov 28, 1929, that I last saw him alive on Nov 28, 1929, and that death occurred, on the date stated above, at 11-50 P. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Blue Baby
1590

CONTRIBUTORY (SECONDARY) 1590
 (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) O. P. Snow M. D.
 , 19 _____ (Address) Queen City

*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 Queen City DATE OF BURIAL Nov 29 1929

20. UNDERTAKER none ADDRESS _____

WHILE IN PRINT, WITH UNFADING INK--THIS IS A PERMANENT RECORD

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

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