

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

Do not use this space.

22 1930

11694

1. PLACE OF DEATH

County Boone Registration District No. 29
Township Dawson Primary Registration District No. 5116
City (No.) St. Ward)

File No.
Registered No.

2. FULL NAME Luz Wade 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. da. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

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

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Feb-17-1852

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
78 | 1 | 10

8. OCCUPATION OF DECEASED

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

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

10. NAME OF FATHER Tom A Wade

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

12. MAIDEN NAME OF MOTHER Don't Know

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Don't Know
(STATE OR COUNTRY)

14. INFORMANT Mrs J H Coate
(Address) Sturgeon, Mo.

15. FILED 4/25 19 30 E. N. Gentry REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Apr 27 19 30

17. I HEREBY CERTIFY, That I attended deceased from Apr 10, 19 30, to Apr 24, 19 30 that I last saw her alive on Apr 27, 19 30, and that death occurred, on the date stated above, at 2:00 p.m. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Paralysis
820
.....
..... (duration) yrs. mos. da.

CONTRIBUTORY (SECONDARY)
(duration) yrs. mos. da.

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?

(Signed) J W Williams, M. D.
, 19 (Address) Sturgeon

*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 Cemetery DATE OF BURIAL 4/28 19 30

20. UNDERTAKER Boone Funeral & U Co Sturgeon, Mo.
ADDRESS

PARENTS

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

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. _____ Registered No. 12
 City _____ (No. _____) St. _____ Ward _____

2. FULL NAME Lucy Wade Riley

(a) Residence. No. _____ St. Wash. (If nonresident give city or town and State)
 (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.

PERSONAL AND STATISTICAL PARTICULARS

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

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)

PARENTS

14. INFORMANT (Address)

15. FILED 6/5/30 E. N. Gentry REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 4/27 1930

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:

Paralysis Hemiplegia
 (duration) _____ yrs. _____ mos. _____ ds.

CONTRIBUTORY (SECONDARY)

750
 (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

46911-5