

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

Do not use this space.

18200

1. PLACE OF DEATH

County St. Louis
Township St. Louis
City St. Louis

Registration District No. 791
Primary Registration District No. 4003

File No. _____
Registered No. 5372
St. _____ Ward _____

2. FULL NAME

Clarence Riffley
(a) Residence. No. 4125th Eastern Ave. St. 11 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 M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Single

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

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

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, _____ hrs. or _____ min.
Alt 36 ✓ ✓

8. OCCUPATION OF DECEASED

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

9. BIRTHPLACE (CITY OR TOWN)

(STATE OR COUNTRY) Tennessee

PARENTS

10. NAME OF FATHER _____

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

12. MAIDEN NAME OF MOTHER W. H. H. H. H. H.

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

14. INFORMANT John D. Hurley (Address) Corner of _____

15. FILED JUN -2 1933 May C. Winkler REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 5/31/32 19

Physician in attendance
HEREBY CERTIFY, That I attended deceased from _____, 19____, to _____, 19____, that I last saw him _____ alive on _____, 19____, and that death occurred, on the date stated above, at _____ 12:00 P. m.

THE CAUSE OF DEATH WAS AS FOLLOWS:

Acute Peritonitis
117A
129
(duration) _____ yrs. _____ mos. _____ ds.
CONTRIBUTORY Peptic Ulcer (SECONDARY)
(duration) _____ yrs. _____ mos. _____ ds.

18. WHERE WAS DISEASE CONTRACTED _____
IF NOT AT PLACE OF DEATH _____
8 DID AN OPERATION PRECEDE DEATH? _____ DATE OF _____
WAS THERE AN AUTOPSY? Yes

WHAT TEST CONFIRMED DIAGNOSIS?
(Signed) J. W. Fennel M.D.
6/2, 1933 (Address) Dep. Coroner

*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 Johnson City Tenn DATE OF BURIAL 6/5 1932

20. UNDERTAKER Johnson City Tenn ADDRESS 2621 _____

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.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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