

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

Do not use this space.

File No. **25293**

1. PLACE OF DEATH

County Schuylers
Township Prairie
City Queen City (No. _____)

Registration District No. 806
Primary Registration District No. 11755

Registered No. _____
St. _____ Ward _____

2. FULL NAME

Charles Rex 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 Male
4. COLOR OR RACE White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED* (write the word) Baby

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

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

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, 4 hrs. or 5 min.

8. OCCUPATION OF DECEASED

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

9. BIRTHPLACE (CITY OR TOWN) Queen City, Mo.
(STATE OR COUNTRY)

PARENTS
10. NAME OF FATHER Ernest Robert Riley
11. BIRTHPLACE OF FATHER (CITY OR TOWN) Schuylers Mo
(STATE OR COUNTRY)
12. MAIDEN NAME OF MOTHER Emma Cecelia Myers
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Schuylers Mo
(STATE OR COUNTRY)

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

15. FILED 8/28/33 REGISTRAR J. J. Jones

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) July 28 1933
17. I 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 _____ m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Blue Baby 15 1/2
15 1/2 (duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY) _____ (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) Joe F. Reed
July 28 19 33 (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 Cemetery DATE OF BURIAL July 28 1933

20. UNDERTAKER Wm M West ADDRESS Queen City Mo

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 CLEARLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

AGE 2-6 1933

