

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

Do not use this space.

1. PLACE OF DEATH

County Randolph
Township Sugar Creek
City Moberly

Registration District No. 735
Primary Registration District No. 3034

File No. 17790
Registered No. 72
Ward

2. FULL NAME

(a) Residence, No. _____
(Usual place of abode)

St. _____ Ward. _____

(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.

Straw Gene Riley

Madison Mo.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX male 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Divorced

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) 9/4/1861

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, hrs. or min.
	<u>72</u>	<u>8</u>	<u>5</u>	

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Retired Farmer

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.

10. Date deceased last worked at this occupation (month and year) _____ 11. Total time (years) spent in this occupation _____

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Madison Co. Mo.

13. NAME Alex Riley

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Kentucky

15. MAIDEN NAME Don't know

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Kentucky

17. INFORMANT Frank Riley
(ADDRESS) Madison Mo. R R

18. BURIAL, CREMATION, OR REMOVAL PLACE Cemeteries DATE May 10 1934

19. UNDERTAKER Frank Riley
(ADDRESS) Madison Mo.

20. FILED 579 1934 Virginia Keller
Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) May 9, 1934

22. I HEREBY CERTIFY, That I attended deceased from May 1, 1934, to May 9, 1934

I last saw him alive on May 9, 1934. Death is said to have occurred on the date stated above, at 7:30 a. m.

The principal cause of death and related causes of importance were as follows:

Hemiplegia Date of onset May 1

Other contributory causes of importance:

Name of operation _____ Date of _____

What test confirmed diagnosis? Physical Was there an autopsy? no

23. If death was due to external causes (violence), fill in also the following: Accident, suicide, or homicide? _____ Date of injury _____, 19 _____

Where did injury occur? _____ (Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place.

Manner of injury _____

Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased? no

If so, specify _____ (Signed) A. L. McCormick, M. D.

(Address) Moberly

JUN 26 1934

FEB 8 1957

#2 *Randolph.*

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS *17790*

E. T. McGaugh, M. D.,
Special Agent,
Jefferson City, Mo.

WASHINGTON

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Dear Sir:

It is essential that death certificates be complete in every particular in order that proper classification may be made. You are therefore requested to make every effort to obtain the following information, indicated by check marks, lacking from the death certificate.

Name: *Straw Gene Riley*
Who died at _____ on *May - 9 - 1934*
Residence: No. _____ St. _____
(If nonresident, city or town)

Length of residence in city or town where death occurred: Years _____ Months _____ Days _____
Sex *M* Color or race *W* Single, ~~married~~, ~~widowed~~ or divorced: _____

Date of birth _____ Age: Years *72* Months *8* Days *5*

Occupation: (a) Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. (b) Industry or business in which work was done, as silk mill, saw mill, bank, etc.

Date deceased last worked at this occupation: Month _____ Year _____
Birthplace (State or country) _____
Birthplace of father (State or country) _____
Birthplace of mother (State or country) _____
Principal cause of death: *Hemiplegia*
caused from cerebral hemorrhage

Other contributory causes of importance _____
Name of operation _____ Date of _____
What test confirmed diagnosis? _____ Was there an autopsy? _____
If death was due to external causes (violence) fill in also the following:
Accident, suicide, or homicide? _____ Date of injury _____, 19 _____
Where did injury occur? _____
(Specify city or town, county and State)

Specify whether injury occurred in industry, in home, or in public place.

Manner of injury _____
Nature of injury _____
Was disease or injury in any way related to occupation of deceased? _____
If so, specify _____
Name of physician _____
Address of physician *Virginia DeLaher*
Signature of Registrar *[Signature]*

This information is sought for statistical purposes only and in order that the official report may be complete and correct. Please reply promptly using the enclosed official envelope which requires no postage.

Reg. Dist. No. *735 -*

Very truly yours,

Primary Reg. Dist. No. *3034*

E. T. McGaugh, M.D.
Special Agent.

S-17790 (1934)