WRITE PLAINLY, 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 state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

REC'D JUL 12 1939

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

20243
Do not use this space.

1. PLACE OF DEATH

(a) County ..... Registration District No. 791

(b) Township ..... Primary Registration District No. 1003 Registered No. 5087

(c) or City St. Louis. Mo. (d) Street No. City Hospital St.
(If death occurred in Hospital or Institution, write its name instead of street and number)

(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME 400 Robert Riley

(a) Residence, No. 4211 Swan St. 18
(Usual place of abode, if no street address, write county or city) (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): Married

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR): Feb. 4., 1902

7. AGE: YEARS 37 | MONTHS 3 | DAYS 30 | If LESS than 1 day, ... hrs. or ..... min.

OCCUPATION
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.: Machinist
9. Industry or business in which work was done, as saw mill, bank, etc.: Fernholtz Mch. Shop
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): Missouri

FATHER
13. NAME: Jos. Riley
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): Missouri

MOTHER
15. MAIDEN NAME: Lucy Craig
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): Georgia

17. INFORMANT (ADDRESS): Aileen Riley, 4211 Swan

18. BURIAL, CREMATION, OR REMOVAL
PLACE: Memorial Park DATE: 6/6/39, 19

19. FUNERAL DIRECTOR (NAME) (ADDRESS): Edith E. Ambruster, 4234 Manchester

20. FILED JUN 6 1939 19 J. F. Bredeck Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR): 6/3/39, 19

22. I HEREBY CERTIFY That I attended deceased from May 1 1939, to June 3, 1939
I last saw alive on June 3, 1939. Death is said to have occurred on the date stated above, at 3.20 A.M.
The principal cause of death and related causes of importance were as follows:

Lobar Pneumonia

Interlobar Empyema

Date of onset

Other contributory causes of importance:

Name of operation ..... Date of .....
What test confirmed diagnosis? Typical H. P. [illegible] 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) N. B. DeRew M. D.
(Address) 1446 S. Sward

(Licensed Embalmer's Statement on Reverse Side)

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

.....Registered Apprentice No.....,

working under my personal supervision.

Signed.....Florenz Eynck

Licensed Embalmer No.....1284

P. O. Address.....St Louis Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.