

791
1008
JUL 12 1939

Registration District No. _____

Primary Registration District No. _____

1. PLACE OF DEATH:

(a) County _____
(b) City or town Saint Louis, Missouri
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Missouri Baptist Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____
(Specify whether
In this community 2 days
years, months or days)

3. (a) PRINT FULL NAME Dorothy Nadine Riley

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Single

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased: June 17, 1934
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
5 0 1 hr. min.

9. Birthplace Dent County Missouri
(City, town, or county) (State or foreign country)

10. Usual occupation Child

11. Industry or business Nil

12. Name Rand Riley

13. Birthplace Dent County Missouri
(City, town, or county) (State or foreign country)

14. Maiden name Mary Alma Byrd

15. Birthplace Phelps County Missouri
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Mrs. Mary Alma Riley

(b) Address Salem, Missouri.

17. (a) Burial (b) Date thereof 6/19/39
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Salem Missouri

18. (a) Signature of funeral director Albert H. Hoppe

(b) Address 4700 Washington Blvd.

19. (a) JUN 17 1939 (b) J. B. [Signature]
(Date received local Registrar) (Licenses Registrar's Signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County _____
(c) City or town Salem
(If outside city or town limits, write "RURAL")
(d) Street No. _____
(If rural, give location)
(e) If foreign born, how long in U. S. A.? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 17
year 1939 hour 2 minute 30 A. M.

21. I hereby certify that I attended the deceased from 6-15-1939 to 6-17-1939.
that I last saw her alive on 6-17-1939
and that death occurred on the date and hour stated above.

Immediate cause of death Sepsis Duration 5 days

Due to Acute Staphylococci osteomyelitis of L. pharynx Duration 6 days

Due to non tubercular

Other conditions (Include pregnancy within 3 months of death) 154

Major findings: Of operations Acute Staph. Osteomyelitis L. pharynx
Of autopsy _____
PHYSICIAN _____
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____
(b) Date of occurrence _____
(c) Where did injury occur? _____ (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____
While at work? _____ (Specify type of place) (e) Means of injury _____

23. Signature M. H. [Signature] (M. D. or other)
Address St. Louis Mo. Date signed 6/17/39

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE 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.

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

Robert G. Lloyd

Licensed Embalmer No. 2971

P. O. Address.....

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.