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.

I X16605

OCT 14 1939

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

791

31230
Do not use this space.

1. PLACE OF DEATH

(a) County ..... Registration District No. 1003

(b) Township ..... Primary Registration District No. ..... Registered No. 8293

(c) or City St. Louis (d) Street No. Homer G. Phillips 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 Infant Riley

(a) Residence, No. 1622 Biddle St. 25
(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: F
4. COLOR OR RACE: Negro
5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (*write* the word)

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) 8-21-39

7. AGE: YEARS | MONTHS | DAYS | If LESS than 1 day, ... hrs. or 5 min.

OCCUPATION
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.
9. Industry or business in which work was done, as 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) St. Louis, Mo.

FATHER
13. NAME Calip Riley
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Miss.

MOTHER
15. MAIDEN NAME Mildred Mayes
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Ill.

17. INFORMANT (ADDRESS) Esther Mays Sherard 2601 N Whittier

18. BURIAL, CREMATION, OR REMOVAL PLACE CITY CEMETERY DATE 9-28-39

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Ira Hamilton City Health Dept

20. FILED SEP 27 1939 J. F. Bredeck Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 8-21- , 1939

22. I HEREBY CERTIFY, That I attended deceased from 8-21- , 1939 to 8-21- , 1939
I last saw her alive on 8-21- , 1939 Death is said to have occurred on the date stated above, at 1:25p m.
The principal cause of death and related causes of importance were as follows:

Atelectasis

Date of onset

Other contributory causes of importance:

Name of operation ..... Date of .....
What test confirmed diagnosis? Clinical Was there an autopsy? Yes

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? .....
If so, specify .....
(Signed) G. E. Pease, M. D.
(Address) 2601 N Whittier St.

(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.....

Licensed Embalmer No.....

P. O. Address.....

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

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