

## MISSOURI STATE BOARD OF HEALTH

## BUREAU OF VITAL STATISTICS

## CERTIFICATE OF DEATH

40626

Do not use this space.

1. PLACE OF DEATH *Ray*  Registration District No. *739*  
 (a) County *Ray* (b) Township *Camden* Primary Registration District No. *9991-5-974* Registered No. \_\_\_\_\_  
 (c) City \_\_\_\_\_ (d) Street No. \_\_\_\_\_ (If death occurred in Hospital or Institution, write its name instead of street and number) St. \_\_\_\_\_  
 (e) Length of residence in city or town where death occurred *100* yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME *AUBRY RIFFE*  
 (a) Residence, No. \_\_\_\_\_ St.  (If nonresident, give city or town and State)  
 (Usual place of abods, if no street address, write county or city)

## PERSONAL AND STATISTICAL PARTICULARS

3. SEX *Male* 4. COLOR OR RACE *Negro* 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) *married*

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

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

7. AGE YEARS MONTHS DAYS If LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.  
*43 1 2*

OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. *farm hand*  
 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) *7/18/39* 11. Total time (years) spent in this occupation \_\_\_\_\_

FATHER 12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Ray County Mo.*  
 13. NAME *Asa Riffe*  
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Ray County Mo.*

MOTHER 15. MAIDEN NAME *Bette Blucher*  
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Ray County Mo.*

17. INFORMANT (ADDRESS) *Frank Riffe, Ray County Mo.*

18. BURIAL, CREMATION, OR REMOVAL PLACE *South West Cem. Co.* DATE *7/20/39*

19. FUNERAL DIRECTOR (ADDRESS) *Gilman & Son, Orrick Mo.*

20. FILED *Oct 6, 1939 Middlebrook* Local Registrar

## MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) *July 18, 1939*

22. I HEREBY CERTIFY That I attended deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_.

I last saw him alive on \_\_\_\_\_, 19\_\_\_\_. Death is said to have occurred on the date stated above, at *3:45 P.M.*

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

*Struck by lightning*

Date of onset

*Just*Other contributory causes of importance: *1st*

Name of operation \_\_\_\_\_ Date of \_\_\_\_\_

What test confirmed diagnosis? \_\_\_\_\_ Was there an autopsy? *No*23. If death was due to external causes (violence), fill in also the following: Accident, suicide, or homicide? *accident* Date of injury *July 18, 1939*Where did injury occur? *farm, S. Fleming, Mo.* (Specify city or town, county, and State)Specify whether injury occurred in industry, in home, or in public place. *farm*Manner of injury *Lightning*

Nature of injury \_\_\_\_\_

24. Was disease or injury in any way related to occupation of deceased? \_\_\_\_\_

If so, specify \_\_\_\_\_

(Signed) *G.W. Gaines* M. D.(Address) *Richmond, Mo.*

STATEMENT BY LICENSED EMBALMER

I, A. V. Gibson, Licensed Embalmer No. 2299

hereby certify that the body recorded on the reverse side of this certificate was embalmed by.....

No. \_\_\_\_\_ or by A. V. Gibson L. E. \_\_\_\_\_, Registered Apprentice No. ~~151~~ 151  
working under my personal supervision.

Signed A. V. Gibson  
Licensed Embalmer No. 2299

**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.)**

FILL IN ANSWERS TO ALL SPACES  
CHECKED IN RED PENCIL.

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BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH

40626

Do not use this space.

1. PLACE OF DEATH
- (a) County Ray Registration District No. 739
- (b) Township Camden Primary Registration District No. 3974 Registered No. \_\_\_\_\_
- (c) City \_\_\_\_\_ (d) Street No. \_\_\_\_\_ 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 Aubrey Riffe
- (a) Residence, No. \_\_\_\_\_ St.  (If nonresident, give city or town and State)  
(Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX m 4. COLOR OR RACE w 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) m

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) 16 1916

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.  
43 1 2

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) \_\_\_\_\_

FATHER 13. NAME \_\_\_\_\_

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) \_\_\_\_\_

MOTHER 15. MAIDEN NAME \_\_\_\_\_

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) \_\_\_\_\_

17. INFORMANT (ADDRESS) \_\_\_\_\_

18. BURIAL, CREMATION, OR REMOVAL PLACE \_\_\_\_\_ DATE \_\_\_\_\_ 19

19. FUNERAL DIRECTOR (ADDRESS) \_\_\_\_\_

20. FILED Dec 6 1934 Man Middleton Local Registrar.

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 7-18 1939

22. I HEREBY CERTIFY, That I attended deceased from \_\_\_\_\_ to \_\_\_\_\_, 19\_\_\_\_.

I last saw him \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_. Death is said to have occurred on the date stated above, at \_\_\_\_\_ m.

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

Date of onset \_\_\_\_\_

Other contributory causes of importance: \_\_\_\_\_

Name of operation \_\_\_\_\_ Date of \_\_\_\_\_

What test confirmed diagnosis? \_\_\_\_\_ Was there an autopsy? \_\_\_\_\_

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. M. Gaine, M. D.  
(Address) Richmond 3005

SUPPLEMENTARY

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.  
CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.  
or information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should sign.

