

Registration District No. 399

Primary Registration District No. 1002

Registrar's No. 1119

1. PLACE OF DEATH:

(a) County Jackson  
(b) City or town Kansas City  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
2825 Troost ave 7  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution none  
(Specify whether  
In this community 24 years  
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson  
(c) City or town Kansas City  
(If outside city or town limits, write "RURAL")  
(d) Street No. 2825 Troost Avenue  
(If rural, give location)  
(e) If foreign born, how long in U. S. A.? \_\_\_\_\_ years.

3. (a) PRINT FULL NAME Mary E. Riley 400

3. (b) If veteran, name war.  (c) Social Security No. none

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

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

7. Birth date of deceased September 22 1862  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
77yrs 5 18 hr. min.

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

10. Usual occupation Hswife

11. Industry or business \_\_\_\_\_

12. Name John McLaughlin 9

13. Birthplace No Record (City, town, or county) (State or foreign country)

14. Maiden name Mary Glover

15. Birthplace Osage County Mo (City, town, or county) (State or foreign country)

16. (a) Informant Mrs. J. S. Riley

(b) Address 2745 Elmwood

17. (a) Burial (b) Date thereof 3 11 1940  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Greenlawn Cemetery

18. (a) Signature of funeral director Bentley Mortuary Inc.

(b) Address 5811 Troost Avenue

19. (a) Mch 11, 1940 (Date received local registrar) M. M. Brown (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 9th - 1940  
year 1940 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from Feb. 23rd 1940 to March 9th, 1940;  
that I last saw her alive on March 6th, 1940 19\_\_\_\_  
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral hemorrhage and hypostatic Bronchopneumonia

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_

Major findings: Of operations \_\_\_\_\_

Of autopsy None

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 A. J. DeMara M.D. (M. D. or other) Supt. K. C. Gen. Hosp., K. C. Mo.  
Address \_\_\_\_\_ Date signed 3-11-40

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

**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

*Guy Buffington*

Licensed Embalmer No. *2756*

P. O. Address *K. C. 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.**