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 OCTOBER is very important.

FEB OCT 12 1940

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 31694

Registration District No. 164 Primary Registration District No. 6229 Registrar's No.

1. PLACE OF DEATH:

(a) County: CEDAR

(b) City or town: Rural-Benton (If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution (Specify whether years, months or days) In this community: 24 yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State: Missouri (b) County: Cedar

(c) City or town: Rural-Benton (If outside city or town limits, write "RURAL")

(d) Street No.: 2 miles N. & 1 mile W. of Jerico Springs. (If rural give location)

(e) If foreign born, how long in U. S. A.? years.

3. (a) PRINT FULL NAME: James William Riley

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

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

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

7. Birth date of deceased: May (Month) 31 (Day) 1877 (Year)

8. AGE: Years 63 Months 5 Days 12 If less than one day: hr. min.

9. Birthplace: Beloit Kans. (City, town, or county) (State or foreign country)

10. Usual occupation: farmer

11. Industry or business:

FATHER 12. Name: John P. Riley

13. Birthplace: Penn. (City, town, or county) (State or foreign country)

MOTHER 14. Maiden name: Mary R. Clagaugh

15. Birthplace: Not known (City, town, or county) (State or foreign country)

16. (a) Informant's own signature: Grace Riley

(b) Address: Jerico Spgs. Mo.

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

(c) Place: burial or cremation: St. James Cem

18. (a) Signature of funeral director: J. Howard

(b) Address: Greenfield Mo.

19. (a) Sept 20 1940 (Date received local registrar) (b) Mrs. Mary Heffner (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month September day 12 year 1940 hour two minute 15 A. M.

21. I hereby certify that I attended the deceased from August 6, 1940, to Sept. 11, 1940; that I last saw him alive on Sept. 11, 1940, and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Carcinoma of the Stomach	?
Due to:	
Due to:	
Other conditions (Include pregnancy within 3 months of death):	
Major findings: Of operations:	
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? (Specify type of place)

While at work? (e) Means of injury:

23. Signature: J. Bennett (M. D. or other) D.O.

Address: Jerico Springs, Mo. Date signed 9/2/40

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 7,
District File Number 10-40-1392
Date Filed 10-7-40

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 J. W. Ward

Licensed Embalmer No. 2832

P. O. Address Greenfield Me

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

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