

No. 2
1-13-40
-17-39
X23159

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

36291

State File No. _____

Registration District No. 784

Primary Registration District No. 101

Registrar's No. 1961

1. PLACE OF DEATH:

(a) County St. Louis

(b) City or town Clayton
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: St. Louis County Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 1 min.
(Specify whether life years, months or days)

In this community life

3. (a) PRINT FULLNAME Riley, Baby Boy

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 single

6. (b) Name of husband or wife _____

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

7. Birth date of deceased Aug. 26 1940
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
<u>0</u>	<u>0</u>	<u>0</u>	<u>0</u> hr. <u>1</u> min.

9. Birthplace Clayton Mo.
(City, town, or county) (State or foreign country)

10. Usual occupation nil.

11. Industry or business _____

MOTHER FATHER {

12. Name Thomas W. Riley

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

14. Maiden name Grace Hall

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

16. (a) Informant Elizabeth Brown

(b) Address St. Louis, County Hospital

17. (a) _____ (b) Date thereof 10/17/40
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) OCT 17 1940 (b) _____
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County St. Louis

(c) City or town Wellston
(If outside city or town limits, write "RURAL")

(d) Street No. 2125a Cherry
(If rural, give location)

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug. day 26
year 1940 hour 11 minute :00 A.M.

21. I hereby certify that I attended the deceased from 8-26-40
_____, 19____, to 8-26-40, 19____;

that I last saw h. im alive on 8-26-40, 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death
Prematurity
Apnea bifida + meningococci

Duration
7 months
7 "

Due to _____

Due to 157 1/2

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? _____

While at work? _____
(Specify type of place) (e) Means of injury

23. Signature J. H. Fauman Jr. M.D.

Address St. Louis Co. Hosp. Date signed _____

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.....

Licensed Embalmer No.....

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, fact should be so stated above.