

Registration District No. 701

Primary Registration District No. 1003

Registrar's No. 1662

1. PLACE OF DEATH: St Louis, Mo
 (a) County _____
 (b) City or town _____
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution: Homer L. Phillips Hospital
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 12 hrs 10 min
 (Specify whether _____)
 In this community _____
 years, months or days)

3. (a) PRINT FULL NAME Lee Archie Riles
 3. (b) If veteran, name war _____ 3. (c) Social Security No. 488-12-8829
 4. Sex M. 5. Color or race Col 6. (a) Single, widowed, married, divorced Married
 6. (b) Name of husband or (wife) Bessie Riles 6. (c) Age of husband or (wife) if alive 35 years
 7. Birth date of deceased 5 1 1891
 (Month) (Day) (Year)

8. AGE: Years 50 Months 9 Days 19 If less than one day _____ hr. _____ min.

9. Birthplace Bearden / Ark.
 (City, town, or county) (State or foreign country)

10. Usual occupation Porter work.

11. Industry or business _____

MOTHER FATHER
 { 12. Name Richard Riles
 { 13. Birthplace Bearden / Ark.
 (City, town, or county) (State or foreign country)
 { 14. Maiden name Marah Jenkins
 { 15. Birthplace Kingland / Ark.
 (City, town, or county) (State or foreign country)

16. (a) Informant's own signature Classie Wilford
 (b) Address 4527 Kennetley Ave
 17. (a) Buried (b) Date thereof 2-21-41
 (Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation Washington Park Cemetery

18. (a) Signature of funeral director Bus Low
 (b) Address 2930 Dickson St.
 19. (a) FEB 21 1941 (b) J. T. Budech
 (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
 (a) State MO (b) County BO
 (c) City or town ST LOUIS 1121
 (If outside city or town limits, write "RURAL")
 (d) Street No. 2814 Dickson St
 (If rural, give location)
 (e) If foreign born, how long in U. S. A.? 0 years

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feby. day 18th
 year 1941 hour 12 minute 15 A. M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;
 that I last saw h_____ alive on _____, 19____;
 and that death occurred on the date and hour stated above.

Immediate cause of death Cerebeller Apoplexy.

Due to _____

Due to _____

Other conditions _____
 (Include pregnancy within 3 months of death)

Major findings: Of operations _____

Of autopsy _____

Duration

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)
 (a) Means of injury 3

23. Signature Thomas F. Callahan (M. D. or other)
 Address Deputy Coroner Date signed 2/21/41

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.

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.....

G. A. [Signature]

Licensed Embalmer No. *2963*

P. O. Address. *2915 Franklin*

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.