

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

40838  
State File No. \_\_\_\_\_  
Registrar's No. 4514

Registration District No. 399  
Primary Registration District No. 1002

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:  
3950 Mercier  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_  
In this community 56 yrs / (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:  
(a) State Missouri (b) County Jackson 042  
(c) City or town Kansas City 3  
(If outside city or town limits, write "RURAL") 2  
(d) Street No. 3923 Wyoming  
(If rural, give location)  
(e) Citizen of foreign country? No (Yes or No)  
If yes, name country \_\_\_\_\_ 10

3. (a) PRINT FULL NAME Margaret Ellen Riley  
3. (b) If veteran, name war No  
3. (c) Social Security No. No

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month December day 4  
year 1941 hour \_\_\_\_\_ minute \_\_\_\_\_ M.  
21. I hereby certify that I attended the deceased from \_\_\_\_\_ 1936 to Dec 4 1941  
that I last saw her alive on Dec. 4, 1941  
and that death occurred on the date and hour stated above.

4. Sex Female 5. Color or race White  
6. (a) Single, widowed, married, divorced Widow  
6. (b) Name of husband or wife Morris W. Riley  
6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
7. Birth date of deceased January 6, 1865  
(Month) (Day) (Year)

Immediate cause of death \_\_\_\_\_  
Myocardial Failure  
Due to Atherosclerosis  
Dry gangrene left leg  
Due to Amputation  
Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_  
Major findings: 97  
Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_

8. AGE: Years Months Days If less than one day  
76 10 28 hr. \_\_\_\_\_ min.

9. Birthplace Lockport New York  
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife

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

12. Name Glynn

13. Birthplace Ireland 4  
(City, town, or county) (State or foreign country)

14. Maiden name No Record

15. Birthplace No Record 01  
(City, town, or county) (State or foreign country)

16. (a) Informant Morris G. Riley

(b) Address 5211 Mission Woods Road

17. (a) Burial (b) Date thereof 11/6/41  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Memorial Park Cem

18. (a) Signature of funeral director Satisfaction Home

(b) Address Kansas City, Kansas

19. (a) 12/5/41 (b) M. M. Crowe  
(Date received local registrar) (Registrar's signature)

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 Edgar Carter M.D. (M.D. or other)  
Address 242 Plaza Medical Bldg Date signed 12/5/41

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

*Dr. Carrier*  
*Alaya med*

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**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.....

*Jimmy S. Huckelton*

Licensed Embalmer No. *4092*

P. O. Address. *H. C. Vann*

**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.**

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

State File No. ....

Registration District No. ....

Primary Registration District No. ....

Registrar's No. 4514

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

1. PLACE OF DEATH:

(a) County .....  
(b) City or town .....  
(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  
In this community .....  
years, months or days)

3. (a) PRINT FULL NAME

*Margaret E. Riley*

3. (b) If veteran, name war

3. (c) Social Security No. ....

4. Sex 7

5. Color or race

6. (a) Single, widowed, married, divorced

6. (b) Name of husband or wife

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

7. Birth date of deceased

(Month)

(Day)

(Year)

8. AGE:

Years

Months

Days

If less than one day

76

min.

9. Birthplace

(City, town, or county)

(State or foreign country)

10. Usual occupation

11. Industry or business

MOTHER FATHER { 12. Name

13. Birthplace

(City, town, or county)

(State or foreign country)

14. Maiden name

15. Birthplace

(City, town, or county)

(State or foreign country)

16. (a) Informant

(b) Address

17. (a)

(Burial, cremation, or removal)

(b) Date thereof

(Month) (Day) (Year)

(c) Place: burial or cremation

18. (a) Signature of funeral director

(b) Address

19. (a)

(Date received local registrar)

(b)

*M. M. Browe*

(Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: month ..... day .....  
year ..... hour ..... minute ..... M.

21. I hereby certify that I attended the deceased from ..... 19..... to ..... 19.....  
that I last saw him ..... alive on ..... 19.....  
and that death occurred on the date and hour stated above.

Immediate cause of death: *Myocardial failure Chronic*

Due to

Due to *arteriosclerosis of aorta gangrene of left leg*

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?

(Specify type of place)

While at work?

(c) Means of injury

23. Signature *C. Cassin M.D.* (M. D. or other)

Address ..... Date signed

5-46838