S. No. 2
M—2-43
5-17-39
I X35697

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 32621

FILED OCT 9

Registration District No. 1947 Primary Registration District No. 3069 Registrar's No. 2227

1. PLACE OF DEATH:

(a) County St. Louis

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

(c) Name of hospital or institution:
At Home 7425 Warner Ave.
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 1 (Specify whether
In this community 33 Years
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County St. Louis 096

(c) City or town Richmond Heights, 8
(If outside city or town limits, write "RURAL") 3

(d) Street No. 7425 Warner Ave.
(If rural, give location)

(e) Citizen of foreign country? No. (Yes or No)

If yes, name country

3. (a) PRINT FULL NAME ZEPHANIAH T. RILEY

3. (b) If veteran, name war No

3. (c) Social Security No. None

4. Sex Male 0

5. Color or race White

6. (a) Single, widowed, married, divorced Married 1

6. (b) Name of husband or wife Josephine A. Riley

6. (c) Age of [redacted] or wife if alive 66 years

7. Birth date of deceased April (Month) 30 (Day) 1873 (Year)

8. AGE: Years 70 Months 4 Days 29 If less than one day 2 hr. 15 min.

9. Birthplace St. Louis (City, town, or county) Mo. 0 (State or foreign country)

10. Usual occupation Retail Hardware

11. Industry or business

FATHER
12. Name James Madison Riley
13. Birthplace St. Louis (City, town, or county) Mo. 0 (State or foreign country)

MOTHER
14. Maiden name Kate Knott
15. Birthplace St. Louis (City, town, or county) Mo. 0 (State or foreign country)

16. (a) Informant Thomas S. Riley
(b) Address 7425 Warner Ave.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 2 1943 (Month) (Day) (Year)
(c) Place: burial or cremation Calvary Cemetery

18. (a) Signature of funeral director Watson-Bockloge
(b) Address 6536 Clayton Rd.

19. (a) OCT 4 1943 (Date of local registration) C. G. McGarvey M.D. (Registrar's signature)

707

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept day 30
year 1943 hour 2 minute 15 a M.

21. I hereby certify that I attended the deceased from Sept. 25, 1943, to Sept 30, 1943
that I last saw him alive on Sept 29, 1943
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Cerebral apoplexy	5 days
Due to	
Due to Hypertension	2 yrs
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations
Of autopsy

830

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 H. F. Cleveland (M. D. or other) M.D.
Address 5930 Southwest Date signed 9-30-43

(Licensed Embalmer's Statement on Reverse Side)

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 John Ogonoske

Licensed Embalmer No. 3398

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.