

FILED SEP 6 1945

State File No. \_\_\_\_\_

Registration District No. 203

Primary Registration District No. 4314

Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH:

(a) County Macou  
(b) City or town Atlanta mo  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: Rural 1  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether)  
In this community All his life  
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State MO (b) County Macou 1  
(c) City or town Atlanta - Rural  
(If outside city or town limit 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 Aug day 30  
year 1945 hour 10 minute a M.

21. I hereby certify that I attended the deceased from Aug 30, 1945, to Aug 30, 1945  
that I last saw him alive on Aug 30, 1945  
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral embolism Duration 1 hour  
Due to Chronic endocarditis 15 years

Due to Rickets during childhood

Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

Major findings: \_\_\_\_\_  
Of operations Op  
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 Paul W. Gillet, D.O. (M. D. or other) D.O.  
Address La Plata Mo Date signed 8/31/45

3. (a) PRINT FULL NAME TEDDIE WAYNE RILEY

3. (b) If veteran, name war no 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 19 1928  
(Month) (Day) (Year)

8. AGE: Years 17 Months 0 Days 11 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace Macou, Co - MO - 1  
(City, town, or county) (State or foreign country)

10. Usual occupation lived on farm

11. Industry or business Farming

12. Name Clarence Riley

18. Birthplace Macou Co MO  
(City, town, or county) (State or foreign country)

14. Maiden name Deborah Danner

15. Birthplace Macou Co MO  
(City, town, or county) (State or foreign country)

16. (a) Informant Clarence Riley

(b) Address Atlanta mo

17. (a) Buried (b) Date thereof Aug 31 1945  
(Burial, cremation, or removal) (Monthly) (Day) (Year)

(c) Place: burial or cremation Naperville Cemetery

18. (e) Signature of funeral director Amberdodding

(b) Address Atlanta mo

19. (a) \_\_\_\_\_ (b) \_\_\_\_\_  
(Date received local registrar) (Registrar's signature)

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

1025

**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.....

H. M. G. Giddings, Registered Apprentice No. ....  
working under my personal supervision.

Signed H. M. G. Giddings

Licensed Embalmer No. 1750

P. O. Address Atlanta Ga

**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.**

Sept

State File No. ....

Registration District No. 203

Primary Registration District No. 5734

Registrar's No. ....

1. PLACE OF DEATH:

(a) County Macon  
 (b) City or town Atlanta  
(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 Teddie Mayne Riley

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

4. Sex \_\_\_\_\_ 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 Aug 19 - 1945  
(Month) (Day) (Year)

8. AGE: Years 17 Months \_\_\_\_\_ Days \_\_\_\_\_ If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_

9. Birthplace \_\_\_\_\_  
(City, town, or county) (State or foreign country)

10. Usual occupation \_\_\_\_\_

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

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) \_\_\_\_\_ (b) Date thereof \_\_\_\_\_  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_

(b) Address \_\_\_\_\_

19. (a) 9-3-1945 (b) Ruth McNeely  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Macon  
 (c) City or town Atlanta, Mo  
(If outside city or town limits, write "RURAL")  
 (d) Street No. Rural  
(If rural, give location)  
 (e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
 If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug Day 30  
 year 1945 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_; to \_\_\_\_\_, 19\_\_\_\_;

and that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_;

and that death occurred on the date and hour stated above.  
 Immediate cause of death \_\_\_\_\_

Duration \_\_\_\_\_

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? \_\_\_\_\_

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

23. Signature \_\_\_\_\_ (M. D. or other) \_\_\_\_\_

Address \_\_\_\_\_ Date signed \_\_\_\_\_

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

SUPPLEMENTARY

5-27858