

1. PLACE OF DEATH:

(a) County Vernon  
(b) City or town Rural Washburn Twp.  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: State Hosp. No 3, Nevada Mo.  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 39-1-17 da.  
(Specify whether  
In this community same period  
years, months or days)

3. (a) PRINT FULL NAME Frances Riley

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

4. Sex Female 5. Color or race White 6. (a) Single, widowed, ~~married~~ divorced

6. (b) Name of husband or wife Thomas F. Riley 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased Nov 23 1874  
(Month) (Day) (Year)

8. AGE: Years 73 Months 1 Days 25 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

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

10. Usual occupation Housework

11. Industry or business Own home

MOTHER FATHER  
12. Name Harve Austing  
13. Birthplace Unknown  
(City, town, or county) (State or foreign country)  
14. Maiden name Unknown  
15. Birthplace Unknown  
(City, town, or county) (State or foreign country)

16. (a) Informant Frances Riley

(b) Address Rte 24 Jasper Mo

17. (a) burial (b) Date thereof 1-21-48  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Paradise Cemetery

18. (a) Signature of funeral director Knell Matney

(b) Address Carthage Mo

19. (a) 1-20-48 (b) Matthew Houser  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jasper  
(c) City or town Rural  
(If outside city or town limits, write "RURAL")  
(d) Street No. Rte 2 - Jasper  
(If rural, give location)  
(e) If foreign born, how long in U. S. A. \_\_\_\_\_ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan. day 18  
year 1948 hour 12:30 A minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from Jan. 1 - 1948  
\_\_\_\_\_ 19 \_\_\_\_\_ to Jan 18 - 1948 \_\_\_\_\_ 19 \_\_\_\_\_

that I last saw her alive on Jan 18 - 1948 \_\_\_\_\_ 19 \_\_\_\_\_  
and that death occurred on the date and hour stated above.

Immediate cause of death Rheumatic Heart Disease

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions Acute Rheumatic Fever  
(Include pregnancy within 3 months of death)

Major findings: \_\_\_\_\_

Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

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 CI

23. Signature R.A. Leith (M. D. or other) \_\_\_\_\_

Address Nevada Mo Date signed 1-28-1948

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

RECEIVED  
District Health Officer No. 7,  
District File Number 12-47-305  
Date Filed 1-22-52

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 Robert H. Knell

Licensed Embalmer No. 4459

P. O. Address Carthage

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.