No. 2
8-43
7-39
X37823

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED SEP 13 1948

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 28146

Registration District No. 318 Primary Registration District No. 1005 Registrar's No. 7694

1. PLACE OF DEATH:

(a) County ~~Peoples Hospital~~

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

(c) Name of hospital or institution: Peoples Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 12 days (Specify whether
In this community 36 years
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County St Louis 96

(c) City or town Webster Groves
(If outside city or town limits, write "RURAL")

(d) Street No. 558 Holland
(If rural, give location)

N.R

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

If yes, name country

3. (a) PRINT FULL NAME Lydia Riley

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex Female

5. Color or race Col

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

6. (b) Name of husband or wife Henry

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

7. Birth date of deceased unknown (Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
about	80			hr. min.

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

10. Usual occupation nil

11. Industry or business

FATHER
12. Name Andrew Wallace
13. Birthplace St Louis (City, town, or county) Mo (State or foreign country)

MOTHER
14. Maiden name Matilda
15. Birthplace unknown (City, town, or county) 9 (State or foreign country)

16. (a) Informant Lillie Shaw
(b) Address 113 Ravine. West Imo

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/2/48 (Month) (Day) (Year)
(c) Place: burial or cremation Father ~~Roxon~~ Dickson Can

18. (a) Signature of funeral director Susie C Lewis
(b) Address 22 EU Chid av Webster Groves

19. (a) SEP 1 1948 (Date received local registrar) (b) J. F. Bredeck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month August 29
year 1948 hour 11 45 minute P M.

21. I hereby certify that I attended the deceased from August 9, 1948, to Aug. 29, 1948; that I last saw her alive on Aug. 29 1948; and that death occurred on the date and hour stated above.

Immediate cause of death Pneumonia Hypostatic

Due to Degenerative Heart Disease

Due to

Other conditions Senility
(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 (e) Means of injury

23. Signature R. Rusan M.D. (M. D. or other)

Address 243 E. Kirkham Webster Groves, Mo Date signed 8-31-48

THOMAS E. RUSAN

(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 .....

Licensed Embalmer No. 2928

P. O. Address 2625 Glasgow

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.

No. 2B
—3-45
P1 X43880

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. Sept
Registrar's No. 7694

Registration District No. 318 Primary Registration District No. 1003

1. PLACE OF DEATH:

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

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) Citizen of foreign country? (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME Lydia Riley
3. (b) If veteran, name war
3. (c) Social Security No.
4. Sex F
5. Color or race B
6. (a) Single, widowed, married, divorced Wid
6. (b) Name of husband or wife
6. (c) Age of husband or wife if alive years
7. Birth date of deceased unk. (Month) (Day) (Year)
8. AGE: Years 80 Months Days If less than one day hr. min.
9. Birthplace Mo (City, town, or county) (State or foreign country)
10. Usual occupation Nil
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) SEP 15 (Registrar's signature) L. D. Bredeck

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July 29 year 1948 hour minute 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	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? (Specify type of place)
While at work? (e) Means of injury
23. Signature (M. D. or other)
Address Date signed

SUPPLEMENTARY

28146