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

#91311  
FEDERAL SECURITY AGENCY  
National Office of Vital Statistics  
FILED NOV 19 1948

MISSOURI DIVISION OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 38575  
Registrar's No. 9713

Registration District No. 318 Primary Registration District No. 1005

1. PLACE OF DEATH:  
(a) County.....  
(b) City or town..... St. Louis, Mo.  
(c) Name of hospital or institution:  
St. Louis City Hospital—Max C. Starkloff  
(d) Length of stay: In hospital or institution.....  
In this community.....

2. USUAL RESIDENCE OF DECEASED:  
(a) State Mo. (b) County.....  
(c) City or town..... St. Louis  
(d) Street No. 1432 Menard Ave.,  
(e) Citizen of foreign country?.....  
If yes, name country.....

3. (a) PRINT FULL NAME JAMES RILEY  
3. (b) If veteran, name war No  
3. (c) Social Security No. None

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month Nov. day 6th  
year 1948 hour 2 minute 30 A.M.  
21. I hereby certify that I attended the deceased from 10/30/48  
that I last saw h. im. alive on Nov. 6th  
and that death occurred on the date and hour stated above.

4. Sex Male  
5. Color or race White  
6. (a) Single, widowed, married, divorced Widowed  
6. (b) Name of husband or wife Unkown  
6. (c) Age of husband or wife if alive..... years  
7. Birth date of deceased Nov. 21, 1877.

Immediate cause of death  
meningitis, type not determined  
Duration 9 days

8. AGE: Years 70 Months 11 Days 15  
9. Birthplace Salem, Missouri  
10. Usual occupation Retired

Due to.....  
Due to.....  
Other conditions.....  
Major findings: Of operations.....  
Of autopsy.....

MOTHER FATHER  
11. Industry or business.....  
12. Name Sam Riley  
13. Birthplace Salem, Mo.  
14. Maiden name Unkown  
15. Birthplace Missouri

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?.....  
(d) Did injury occur in or about home, on farm, in industrial place, in public place?.....

16. (a) Informant Mrs. Frank Jones  
(b) Address Crystall City, Mo.  
17. (a) Burial (b) Date thereof Nov. 9/48.  
(c) Place: burial or cremation Herculaneum, Mo.  
18. (a) Signature of funeral director Pollite Fun. Home  
(b) Address Crystall City, Mo.  
19. (a) NOV 8 1948 (b) J. B. Basater

23. Signature Frank J. Matz 1515 Lafayette 11/6/48 (other).....  
Address..... Date signed.....  
(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 Gentry Pollette

Licensed Embalmer No. 3481

P. O. Address Crystal City, Mo.

**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.**