

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **7591**
Registrar's No. **11**

FILED MAR 2 1954

BIRTH NO. _____ REG. DIST. NO. **374** PRIMARY REG. DIST. NO. **4650**

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

1. PLACE OF DEATH a. COUNTY Worth			2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY Worth		
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Sheridan		c. LENGTH OF STAY (in this place) 8 years	c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Sheridan		1130 0
d. FULL NAME OF HOSPITAL OR INSTITUTION			d. STREET ADDRESS (If rural, give location)		
3. NAME OF DECEASED (Type or Print) a. (First) Grace		b. (Middle) A	c. (Last) Agnes Riley	4. DATE OF DEATH (Month) (Day) (Year) February 21, 1954	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH Jan. 7, 1903	9. AGE (In years last birthday) 51	IF UNDER 1 YEAR: Months _____ Days _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housekeeper	10b. KIND OF BUSINESS OR INDUSTRY Own Home	11. BIRTHPLACE (City and State or Foreign Country) St. Joseph, Missouri		12. CITIZEN OF WHAT COUNTRY? U. S.	
13a. FATHER'S NAME Benjamin F. Lisle		13b. MOTHER'S MAIDEN NAME Cora Rickabaugh		14. NAME OF HUSBAND OR WIFE Robert H. Riley	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO. <input checked="" type="checkbox"/>	17. INFORMANT'S SIGNATURE OR NAME ADDRESS Robert H. Riley - Sheridan, Missouri			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)	MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH 2 years
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Carcinoma of Breast	ANTECEDENT CAUSES				
*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.	Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.				
	DUE TO (b) _____				
	DUE TO (c) _____				
II. OTHER SIGNIFICANT CONDITIONS	Conditions contributing to the death but not related to the disease or condition causing death.				
19a. DATE OF OPERATION Apr 52	19b. MAJOR FINDINGS OF OPERATION Carcinoma uterus				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
27a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)		170x	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from Dec 5, 1953 , to Feb 20, 1954 , that I last saw the deceased alive on Feb 18, 1954 , and that death occurred at 2:55 A.M. , from the causes and on the date stated above.					
23a. SIGNATURE E. P. Nesbitt M.D.		(Degree or title)	23b. ADDRESS Sheridan Mo.		23c. DATE SIGNED 2/21/54
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 2-23-1954	24c. NAME OF CEMETERY OR CREMATORY Sheridan Cemetery	24d. LOCATION (City, town, or county) (State) Sheridan, Missouri		
DATE REC'D BY LOCAL REG. Feb 25 1954	REGISTRAR'S SIGNATURE Kato E. Dawson	345	25. FUNERAL DIRECTOR'S SIGNATURE Bill Dunfee		ADDRESS St. Louis City Mo.

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 _____

Student Embalmer No. _____

working under my personal supervision.

Student
Student Embalmer

Signed Bill A. Dunfee

Licensed Embalmer No. 4908

P. O. Address Grant 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.