No. 300
10-48

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

THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

FILED OCT 27 1954

State File No. 33456

BIRTH NO. _____ REG. DIST. NO. 99 PRIMARY REG. DIST. NO. 5377 Registrar's No. 59

0320 1

1. PLACE OF DEATH
a. COUNTY: DeKalb
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Maysville (Rural)
c. LENGTH OF STAY (In this place): 10yrs
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location):

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Missouri
b. COUNTY: DeKalb
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Maysville (Rural)
d. STREET ADDRESS (If rural, give location): 0320 0

3. NAME OF DECEASED (Type or Print)
a. (First): GRACE
b. (Middle): L.
c. (Last): RIFFIE

4. DATE OF DEATH: (Month) Oct. (Day) 9 (Year) 1954

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If under 1 year: Months / Days	If under 24 hrs.: Hours / Min.
Female	White	Married	Nov. 3 1887	66		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Amity Missouri 0
12. CITIZEN OF WHAT COUNTRY? U.S.

13a. FATHER'S NAME: Henry C. Nichols
13b. MOTHER'S MAIDEN NAME: Laura A. Dewey
14. NAME OF HUSBAND OR WIFE: Grover Riffie

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT'S SIGNATURE OR NAME, ADDRESS: Grover Riffie Maysville Mo.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH. Enter only one cause per line for (a), (b), and (c).

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Coronary Thrombosis

ANTECEDENT CAUSES

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.

INTERVAL BETWEEN ONSET AND DEATH: 15 Min? Dead on arrival

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION: 4201
20. AUTOPSY? YES ☐ NO ☐

21a. 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):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21e. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Death 19 54 to Arrival 19 —, *that I last saw the deceased alive on* Oct. 9, 19 54, *and that death occurred at* 2:30 P *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Wm Harold Fowler MD
23b. ADDRESS: Maysville, Mo
23c. DATE SIGNED: 10/10/54

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 10-12-54
24c. NAME OF CEMETERY OR CREMATORY: Amity
24d. LOCATION (City, town, or county) (State): Amity Missouri

DATE REC'D BY LOCAL REG.: 10-18-54
REGISTRAR'S SIGNATURE: Rosco Davidson
25. FUNERAL DIRECTOR'S SIGNATURE, ADDRESS: PILCHER FUNERAL HOME MAYSVILLE MO.

(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.....

working under my personal supervision.

Student Embalmer No.....

Signed.....
Student Embalmer

Signed C.J.Pilcher
Licensed Embalmer No. 3960

P. O. Address Maysville 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.