

FILED NOV 22 1954

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

39759

State File No. 2455

BIRTH NO. _____ REG. DIST. NO. 317 PRIMARY REG. DIST. NO. 500 Registrar's No. _____

1. PLACE OF DEATH a. COUNTY St. Louis		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Mo. b. COUNTY St. Louis	
b. CITY (If rural, county, Illinois, Indiana, Michigan, Minnesota, New York, Ohio, Pennsylvania, Wisconsin, or Missouri) OR TOWN Rural Area		c. CITY OR TOWN St. Louis Co. d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>	
c. LENGTH OF STAY (In this place) 2 Yrs		STREET ADDRESS (If rural, give location) Gravois & Kennerly Rds.	
d. FULL NAME OF HOSPITAL OR INSTITUTION Gravois Rest Home			

3. NAME OF DECEASED (Type or Print) a. (First) ATILLA b. (Middle) S c. (Last) RILEY			4. DATE OF DEATH (Month) (Day) (Year) 10-20-1954		
5. SEX F	6. COLOR OR RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH 7-15-1873	9. AGE (In years last birthday) 81	IF UNDER 1 YEAR: Months _____ Days _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY At home		11. BIRTHPLACE (City and State or Foreign Country) St. Louis Mo.	
12. CITIZEN OF WHAT COUNTRY? USA					

13a. FATHER'S NAME George Schaaf		13b. MOTHER'S MAIDEN NAME Unknown		14. NAME OF HUSBAND OR WIFE Joseph W Riley	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) _____ (If yes, give war or date of service) _____		16. SOCIAL SECURITY NO. None		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Mrs R F Howse Washington D.C.	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))		MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) A. S. C. V. Disease		II. OTHER SIGNIFICANT CONDITIONS			
*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.		Antecedent Causes			
		Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.			
		DUE TO (b) _____			
		DUE TO (c) _____			

19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
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) (Min)		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 June 1954, to Oct 15, 1954, that I last saw the deceased alive on Oct 15, 1954, and that death occurred at 4:30 a.m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) Frank Huck M.D.		23b. ADDRESS Fenton, Mo.		23c. DATE SIGNED 10/21/54	
24a. BURIAL, CREMATION, REMOVAL (Specify) Removal		24b. DATE 10-22-1954		24c. NAME OF CEMETERY OR CREMATORY Bellefontaine Cem.	
				24d. LOCATION (City, town, or county) (State) St. Louis Mo.	

DATE RECEIVED BY LOCAL REG. 10/21/54		REGISTRAR'S SIGNATURE Robert S. Sommer		FUNERAL DIRECTOR'S SIGNATURE ADDRESS Frank F. Howse Washington D.C.	
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

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.....
Signature of Student Embalmer

Signed.....

Leslie Welch

Licensed Embalmer No. 439

P. O. Address Helmer, Ga

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting. _
If this body is not embalmed, fact should be so stated above.