

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

FILED JUL 20 1956

State File No. \_\_\_\_\_  
Registrar's No. **5842**

BIRTH NO. _____		REG. DIST. NO. <b>318</b>		PRIMARY REG. DIST. NO. <b>1003</b>		Registrar's No. <b>5842</b>		
1. PLACE OF DEATH a. COUNTY _____				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>Missouri</b> b. COUNTY _____				
b. CITY (If outside corporate limits, write RURAL and give town) <b>St. Louis</b>		c. LENGTH OF STAY (In this place) _____		c. CITY OR TOWN <b>St. Louis</b>		d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>		
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>1220 Benton Street</b>				e. STREET ADDRESS (If rural, give location) <b>26 1220 Benton Street</b>				
3. NAME OF DECEASED (Type or Print) a. (First) <b>NELLIE</b>		b. (Middle) _____		c. (Last) <b>RILEY</b>		4. DATE OF DEATH (Month) (Day) (Year) <b>June 19-1956</b>		
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Divorced</b>		8. DATE OF BIRTH <b>Oct. 25-1896</b>		9. AGE (In years last birthday) <b>59</b>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 2 HRS. Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housework</b>			10b. KIND OF BUSINESS OR INDUSTRY _____		11. BIRTHPLACE (City and State or Foreign Country) <b>St Paul, Minn.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13a. FATHER'S NAME <b>William R. Riley</b>			13b. MOTHER'S MAIDEN NAME <b>Annetta Dean</b>		14. NAME OF HUSBAND OR WIFE _____			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>Unknown</b>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <b>Mrs. John Dennis, House Springs, Mo.</b>				
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, asphyxia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Suffocation, from inhalation of natural gas in home on June 19th 1956, while suffering from a temporary mental aberration</b> ANTECEDENT CAUSES (b) <b>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.</b> DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS (d) <b>Conditions contributing to the death but not related to the disease or condition causing death.</b>				INTERVAL BETWEEN ONSET AND DEATH _____		
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION <b>aberration E972x</b>				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT OR SUICIDE (Specify) <b>Suicide</b>		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>Home</b>		21c. CITY, TOWN, OR TOWNSHIP (COUNTY) (STATE) <b>St Louis Mo</b>				
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) <b>June 19 56 9 p.m.</b>		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 _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ m., from the causes and on the date stated above.								
23a. SIGNATURE (Degree or title) <b>Patrick E. Taylor, M.D.</b>				23b. ADDRESS <b>1300 Clark</b>		23c. DATE SIGNED <b>6. 19. 56</b>		
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		24b. DATE <b>June 22-1956</b>	24c. NAME OF CEMETERY OR CREMATORY <b>Calvary Cemetery</b>		24d. LOCATION (City, town, or county) (State) <b>St. Louis, Mo.</b>			
DATE REC'D BY LOCAL REG. <b>JUN 20 1956</b>		REGISTRAR'S SIGNATURE <b>J. Earl Smith, M.D.</b>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>Leidner Undertaking Co. 2223 St. Louis Av.</b>				

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

2209

**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 *Stanley H. Dixon*  
Licensed Embalmer No. *4195*  
P. O. Address *H. L.*

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.