

Health,
& Welfare
S. Public
th Service

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

44567
STATE FILE NUMBER
5723

FILED DEC 18 1957

Registration District No. 149 Primary Registration District No. 1002

Registrar's No. 5723

S. 300
v. 1-57

1. PLACE OF DEATH a. COUNTY JACKSON		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MISSOURI b. COUNTY JACKSON	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN KANSAS CITY		c. CITY OR TOWN KANSAS CITY	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION KRESTWOODS HOSPITAL		d. STREET ADDRESS (If outside, give location) 900 WEST 96TH TERR	

3. NAME OF DECEASED (Type or print) First EDWIN Middle ANDREW Last RILEY			4. DATE OF DEATH Month NOV. Day 30. Year 1957		
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5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH MAR. 4. 1889	9. AGE (In years last birthday) 67	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MANAGER & OPERATOR	10b. KIND OF BUSINESS OR INDUSTRY PALACE BOWLING ALLEY	11. BIRTHPLACE (City and state or country) KANSAS CITY MISSOURI	12. CITIZEN OF WHAT COUNTRY? U. S. A.
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13a. FATHER'S NAME ALEXANDER RILEY	13b. MOTHER'S MAIDEN NAME ETTA HAWKS	14. NAME OF HUSBAND OR WIFE SUSIE IRENE RILEY
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No	16. SOCIAL SECURITY NO. 487-09-5613	17. INFORMANT Address MRS. SUSAN IRENE RILEY 900 WEST 94TH TERR KANSAS CITY, MO.
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Cerebral Hemorrhage RT.		INTERVAL BETWEEN ONSET AND DEATH 6 hrs.
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) Hypertensive Cardiovascular Disease	4 yrs.
	DUE TO (c) Generalized Arteriosclerosis	4 yrs.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) None -
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20c. TIME OF INJURY Hour a.m. p.m.	20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION COUNTY STATE
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21. I attended the deceased from April 1955 to 30 Nov 57 and last saw him alive on 30 Nov-1957 Death occurred at 5:15 P. m on the date stated above; and to the best of my knowledge, from the causes stated.	
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22a. SIGNATURE (Degree or title) James W. Downey M.D.	22b. ADDRESS 425 E 63rd K.P. MO	22c. DATE SIGNED 12-3-57
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23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE DEC. 3-1957	23c. NAME OF CEMETERY OR CREMATORY MT. MORIAH CEMETERY	23d. LOCATION (City, town, or county) (State) KANSAS CITY MISSOURI
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24. FUNERAL DIRECTOR D.W. NEWCOMER'S SONS	ADDRESS 1331 BRUSH CREEK KANSAS CITY, MO.	25. DATE RECD. BY LOCAL REG. 12-3-57	26. REGISTRAR'S SIGNATURE neva minshall
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(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

James W. Downey

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 *Albert L. Savage*

Licensed Embalmer No. *4812*

P. O. Address *Ann Arbor, Mich*

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.