

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-025247

STATE FILE NUMBER

1958 AUG 11

Registration District No. 133

Primary Registration District No. 3022

Registrar's No. 104

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S. 300
1-57

1. PLACE OF DEATH a. COUNTY <u>HARRISON</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo</u> b. COUNTY <u>HARRISON</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Bethany</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <u>Eagleville</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Reid Hospital Clinic</u> Length of stay in 1b <u>1 DAY</u>		d. STREET ADDRESS (If outside, give location) <u>NONE</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First Middle Last <u>Leola Gay Riley</u>			4. DATE OF DEATH Month Day Year <u>July 29, 1958</u>				
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 15, 1897</u>		9. AGE (In years less birthday) <u>61</u>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Druggist</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Drug Store</u>		11. BIRTHPLACE (City and state or country) <u>Mo</u>		12. CITIZEN OF WHAT COUNTRY? <u>US</u>	

13a. FATHER'S NAME <u>Charles L. Riley</u>		13b. MOTHER'S MAIDEN NAME <u>Iona Travis</u>		14. NAME OF HUSBAND OR WIFE <u>Vada Riley</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>Yes 1917-1918</u>		16. SOCIAL SECURITY NO. <u>500-36-1338</u>		17. INFORMANT Address <u>Vada Riley, Eagleville, Mo</u>	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u>			INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Coronary Heart Disease</u>				<u>3 years</u>
DUE TO (c) <u>Hypertensive Cardio-Vascular Disease</u>				<u>8 years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>--</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	

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.) <u>-----</u>		
20c. TIME OF INJURY Hour a.m. --- p.m. Month, Day, Year <u>-----</u>			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.) <u>-----</u>		20f. CITY, TOWN, OR LOCATION <u>Bethany, Missouri</u>		COUNTY STATE	

21. I attended the deceased from 11/22/50 to 7/29/58 and last saw ^{her} _{him} alive on 7/29/58
Death occurred at 11:15 PM on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <u>Leola Gay Riley</u> (Degree or title) <u>D.O.</u>		22b. ADDRESS <u>Bethany, Missouri</u>		22c. DATE SIGNED <u>8/1/58</u>	
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>Aug 1, 1958</u>		23c. NAME OF CEMETERY OR CREMATORY <u>MADONIC Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Eagleville, Mo</u>	
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24. FUNERAL DIRECTOR <u>Harold W. Bugger</u>		ADDRESS <u>Eagleville, Mo</u>		25. DATE RECD. BY LOCAL REG. <u>8-4-58</u>		26. REGISTRAR'S SIGNATURE <u>Gella Mayey</u>	
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(Licensed Embalmer's Statement on Reverse Side)

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.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

AUG 15 1958

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 *Leland W. Boyer*

Licensed Embalmer No. *4762*

P. O. Address *Engleville, 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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.