

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-023325  
STATE FILE NUMBER

FILED JUN 18 1959

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_ Registration No. **5465**

S. 300  
1-57

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X

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

1. PLACE OF DEATH a. COUNTY <b>St. Louis</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Kansas</b> b. COUNTY _____	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>ST. LOUIS, MISSOURI</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>Lawrence</b>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>BARNES HOSPITAL</b>		Length of stay in lb _____	d. STREET ADDRESS (If outside, give location) <b>1224 Delaware</b>
3. NAME OF DECEASED (Type or print) First <b>HARRIETT</b> Middle <b>FAYE</b> Last <b>RILEY</b>			4. DATE OF DEATH Month <b>JUNE</b> Day <b>8</b> Year <b>1959</b>
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Feb. 22, 1905</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>practical nurse</b>		10b. KIND OF BUSINESS OR INDUSTRY _____	9. AGE (In years last birthday) <b>54</b>
11. BIRTHPLACE (City and state or country) <b>Crotty, Kansas</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13a. FATHER'S NAME <b>F. Fred Johnston</b>		13b. MOTHER'S MAIDEN NAME <b>M. Lena Elliott</b>	14. NAME OF HUSBAND OR WIFE <b>unknown</b>
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no none</b>		16. SOCIAL SECURITY NO. <b>unknown</b>	17. INFORMANT <b>Keith Wright, Lawrence, Kansas</b>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>ORTHOSTATIC PNEUMONIA</b>			INTERVAL BETWEEN ONSET AND DEATH <b>4 DAYS</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <b>PERSISTENT CARCINOMA OF CERVIX WITH WIDESPREAD METASTASES</b>			<b>10 YEARS</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>171X</b>			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.)	
20c. TIME OF INJURY Hour _____ Month _____ Day _____ Year _____ 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
21. I attended the deceased from <b>MAY 10, 1959</b> to <b>JUNE 8, 1959</b> and last saw her/him alive on <b>JUNE 8, 1959</b> Death occurred at <b>3:00 A.M.</b> on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <b>C. Vermillion, M.D.</b>		22b. ADDRESS <b>BARNES HOSPITAL</b>	22c. DATE SIGNED <b>6/8/59</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	23b. DATE <b>June 8, 1959</b>	23c. NAME OF CEMETERY OR CREMATORY <b>local</b>	23d. LOCATION (City, town, or county) (State) <b>Lawrence, Kansas</b>
24. FUNERAL DIRECTOR <b>C.R. Lupton &amp; Sons, St. Louis, Mo.</b>		25. DATE RECD. BY LOCAL REG. <b>JUN 8 '59</b>	26. REGISTRAR'S SIGNATURE <b>Earl Smith, M.D.</b>

*mrb.*

VS JUN - 6 1960

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 *Arnold W. Schoene* .....

Licensed Embalmer No. *3864* .....

P. O. Address *St. Louis, 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.