

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-029606

FILED VS AUG 31 1959/65

Registration District No. _____ Primary Registration District No. 5611 Registrar's No. 5

STATE FILE NUMBER

DED

1. PLACE OF DEATH a. COUNTY <u>Johnson</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) <u>Missouri</u> b. COUNTY <u>Johnson</u>			
b. CITY (If outside corporate limits, give TOWNSHIP only) <u>Post oak twp</u>		Length of stay in lb <u>35 yrs</u>		c. CITY OR TOWN <u>Post oak twp</u>	
c. FULL NAME OF (If NOT in hospital, give location) <u>mi 7 W Post oak</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>Childress Rt 1</u>	
3. NAME OF DECEASED (Type or print) First <u>CHARLES</u> Middle <u>ALLEN</u> Last <u>RILEY</u>			4. DATE OF DEATH Month <u>Aug</u> Day <u>26</u> Year <u>1959</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>7/3/1894</u>	9. AGE (last birthday) <u>85</u>	IF UNDER 1 YEAR Months <u>1</u> Days <u>23</u> Hours <u>-</u> Min. <u>-</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farmer</u>		11. BIRTHPLACE (City and state or country) <u>Illinois</u>	
12. CITIZEN OF WHAT COUNTRY <u>USA</u>		13a. FATHER'S NAME <u>Daniel Riley</u>		13b. MOTHER'S MAIDEN NAME <u>Mary L Meyers</u>	
14. NAME OF HUSBAND OR WIFE <u>Hannah Riley</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? <u>No</u>		16. SOCIAL SECURITY NO. <u>No</u>	
17. UNIFORMANT <u>Master Riley Childress Mo Rt 1</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>pneumonia</u> DUE TO (b) <u>Coronary Heart (Dropsy)</u> DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH <u>5 da</u> <u>9-1-59</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition-given in PART I (a) <u>Cardiac asthma</u>			PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		
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 _____ a.m. _____ p.m. Month, Day, Year _____		20d. INJURY OCCURRED WHILE AT WORK <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 <u>4-1-59</u> to <u>8-26-59</u> and last saw her alive on <u>8-20-59</u> Death occurred at <u>5 AM, 8-26-59</u> h. m on the date stated above, and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <u>Schaberg</u> (Degree or title)		22b. ADDRESS <u>Clinton Mo</u>		22c. DATE SIGNED <u>8-26-59</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>Aug 28 1959</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Carpenter</u>		23d. LOCATION (City, town, or county) (State) <u>Johnson County Mo</u>	
24. FUNERAL DIRECTOR <u>SCHABERG S</u> ADDRESS <u>Clinton Mo</u>		25. DATE RECD. BY LOCAL REG. <u>Aug 29, 1959</u>		26. REGISTRAR'S SIGNATURE <u>Jewcock</u>	

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

Ambulance & Funeral Service

(Licensed Embalmer's Statement on Reverse Side)

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by _____
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed F. L. Schaberg

Licensed Embalmer No. 4513

P. O. Address Clinton J.

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.