

**JURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH**

**59-034930**

FILED VS SEP 28 1959

STATE FILE NUMBER

Registration District No. 28-1 Primary Registration District No. 4515 Registrar's No. 90

ENDED

1. PLACE OF DEATH a. COUNTY <b>Sullivan</b>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Sullivan</b>		
b. CITY (If outside corporate limits, give TOWNSHIP only) <b>Milan</b>		Length of stay in 1b <b>9 days</b>	c. CITY OR TOWN <b>Green City</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Sullivan Co. Memorial Hosp.</b>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>No street address</b>	
3. NAME OF DECEASED (Type or print) First <b>Rebecca</b> Middle <b>Maude</b> Last <b>Riley</b>			4. DATE OF DEATH <b>Sept. 16, 1959</b> Month Day Year		
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>10/24/1883</b>	9. AGE (last birthday) <b>75</b>	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House wife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	11. BIRTHPLACE (City and state or country) <b>Taylor Co., Iowa</b>		12. CITIZEN OF WHAT COUNTRY <b>USA</b>
13a. FATHER'S NAME <b>J. W. Hanshaw</b>		13b. MOTHER'S MAIDEN NAME <b>Elizabeth Sims</b>		14. NAME OF HUSBAND OR WIFE <b>Claude M. Riley</b>	
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>None</b>	17. INFORMANT Address <b>Mrs. Hallene Cochran, Green City, Mo.</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) <u>Cerebral aneurysm</u>					INTERVAL BETWEEN ONSET AND DEATH <u>10 days</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Generalized arteriosclerosis</u>				PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" 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 <u>Green City, Sullivan Co., Mo.</u>			
21. I attended the deceased from <u>Sept 10, 1959</u> to <u>Sept 16, 1959</u> and last saw her <u>Sept 16, 1959</u> alive on <u>Sept 16, 1959</u> . Death occurred at <u>3:40 a.m.</u> on the date stated above, and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <u>Dean S. [Signature]</u> (Degree or title)		22b. ADDRESS <u>Milan, Mo</u>		22c. DATE SIGNED <u>9/18/59</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>9/18/1959</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Olivet Cemetery</b>	23d. LOCATION (City, town, or county) (State) <b>Green City, Mo.</b>		
24. FUNERAL DIRECTOR ADDRESS <u>Blenn E. Heat &amp; Son, Green City, Mo.</u>		25. DATE RECD. BY LOCAL REG. <u>9-21-59</u>	26. REGISTRAR'S SIGNATURE <u>Mrs. M. W. Beecher</u>		

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

**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 Harold R. Lent

Licensed Embalmer No. 4689  
P. O. Address Green City,

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.