

UNITED STATES DEPARTMENT OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS FEB 16 1960

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STATE FILE NUMBER

Registration District No. 170 Primary Registration District No. --- Registrar's No. 25

ENDED

|  |  |   |  |   |   |  |   |  |                                   |   |  |                              |  |
|--|--|---|--|---|---|--|---|--|-----------------------------------|---|--|------------------------------|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Laelede</b>  |  |   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Missouri</b> COUNTY <b>Laelede</b>                     |   |  |   |  |                                   |   |  |                              |  |
| b. CITY (If outside corporate limits, give TOWNSHIP only)<br>OR TOWN <b>RURAL Smith T.S.</b>   |  | Length of stay in 1b<br><b>13 Yrs.</b>  |  | c. CITY OR TOWN <b>Lebanon</b>  |   | Inside Limits<br>Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |   |  |                                   |   |  |                              |  |
| c. FULL NAME OF (If NOT in hospital, give location)<br>HOSPITAL OR INSTITUTION <b>Lebanon Rt. 4</b>  |  |   | Inside Limits<br>Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>     |   | d. STREET ADDRESS (If outside, give location)<br><b>Rt. 4</b>       |  | Reside on Farm<br>Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |  |                                   |   |  |                              |  |
| 3. NAME OF DECEASED<br>(Type or print)<br>First <b>ELIZABETH</b> Middle <b>FRANCIS</b> Last <b>RILEY</b>   |  |   |  | 4. DATE OF DEATH<br>Month <b>Feb.</b> Day <b>6,</b> Year <b>1960</b>  |   |  |   |  |                                   |   |  |                              |  |
| 5. SEX<br><b>Female</b>  |  | 6. COLOR OR RACE<br><b>White</b>  |  | 7. Married <input type="checkbox"/> Never Married <input type="checkbox"/><br>Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/> |   | 8. DATE OF BIRTH<br><b>10-9-71</b>   |   | 9. AGE (last birthday)<br><b>88</b>  |                                   | IF UNDER 1 YEAR<br>Months Days Hours Min.           |  | IF UNDER 24 HR<br>Hours Min. |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Housewife</b>  |  |   | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Domestic</b>                                     |   | 11. BIRTHPLACE (City and state or country)<br><b>Roehelli, Ill.</b> |  |   | 12. CITIZEN OF WHAT COUNTRY<br><b>U.S.A.</b>   |                                   |   |  |                              |  |
| 13a. FATHER'S NAME<br><b>John Rahially</b>   |  |   |  | 13b. MOTHER'S MAIDEN NAME<br><b>Catherine Meade</b>   |   |  |   | 14. NAME OF HUSBAND OR WIFE<br><b>Meaurice Riley</b>   |                                   |   |  |                              |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, go, or unknown) (If yes, give war or dates of service)<br><b>No.</b>  |  |   | 16. SOCIAL SECURITY NO.<br><b>None.</b>  |   | 17. INFORMANT<br>Address<br><b>Mr. J P. Riley, Lebanon, Mo.</b>     |  |   |  |                                   |   |  |                              |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Generalized Arteriosclerosis severe</b>   |  |   |  |   |   |  |   |  |                                   | INTERVAL BETWEEN ONSET AND DEATH<br><b>10 years</b> |  |                              |  |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.<br>DUE TO (b) _____<br>DUE TO (c) _____   |  |   |  |   |   |  |   |  |                                   |   |  |                              |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)  |  |   |  |   |   |  |   | PART III. If deceased was female was there a pregnancy in last 90 days.<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown |                                   |   |  |                              |  |
| 19. WAS AUTOPSY PERFORMED?<br>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<br>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 <b>Jan 1959</b> to <b>Feb 1960</b> and last saw her alive on <b>2/5/60</b><br>Death occurred at <b>1:00 A.M.</b> on the date stated above, and to the best of my knowledge, from the causes stated. |  |   |  |   |   |  |   |  |                                   |   |  |                              |  |
| 22a. SIGNATURE<br><i>E. W. Froelich, MD</i> (Deceased's name)  |  |   |  |   |   | 22b. ADDRESS<br><b>Lebanon Mo.</b>   |   |  | 22c. DATE SIGNED<br><b>2-6-60</b> |   |  |                              |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |  | 23b. DATE<br><b>2-8-60</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Catholic Cemetery</b>  |   |  | 23d. LOCATION (City, town, or county)<br><b>Lebanon, Mo.</b>                          |  |                                   |   |  |                              |  |
| 24. FUNERAL DIRECTOR<br><i>J. B. Palmgren</i> ADDRESS <b>Lebanon, Mo.</b>  |  |   |  | 25. DATE RECD. BY LOCAL REG.<br><b>2-8-1960</b>   |   |  |   | 26. REGISTRAR'S SIGNATURE<br><i>Hella L. Gray</i>  |                                   |   |  |                              |  |

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 Stanley's R. Palm

Licensed Embalmer No. 4810

P. O. Address Lebanon, ?

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.