

FEDERAL DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS APR 28 1960

60-016376

STATE FILE NUMBER

Registration District No. 225 Primary Registration District No. 3053 Registrar's No. 79

| | | | |
|--|--|---|---|
| 1. PLACE OF DEATH a. COUNTY Phelps | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Maries | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Rolla | | Length of stay in 1b 24 hrs. | c. CITY OR TOWN Vichy |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Phelps Co. Memorial Hosp. | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | d. STREET ADDRESS (If outside, give location) - - - - - |
| | | Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | |

| | | | | |
|--|--|--|---|--|
| 3. NAME OF DECEASED (Type or print) First ROBERT Middle FRANCIS Last RILEY | | | 4. DATE OF DEATH Month April Day 23 Year 1960 | |
|--|--|--|---|--|

| | | | | | | |
|-----------------------|----------------------------------|---|--------------------------------------|-------------------------------------|---|------------------------------|
| 5. SEX Male | 6. COLOR OR RACE White | 7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH 2/16/1900 | 9. AGE (last birthday) 60 | IF UNDER 1 YEAR Months Days Hours Min. | IF UNDER 24 HR Hours Min. |
|-----------------------|----------------------------------|---|--------------------------------------|-------------------------------------|---|------------------------------|

| | | | |
|---|---|--|---|
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Airway Operation Specialist | 10b. KIND OF BUSINESS OR INDUSTRY US Government | 11. BIRTHPLACE (City and state or country) Belle Plain, Iowa | 12. CITIZEN OF WHAT COUNTRY USA |
|---|---|--|---|

| | | |
|--|--|---|
| 13a. FATHER'S NAME Tom Riley | 13b. MOTHER'S MAIDEN NAME Maude Little | 14. NAME OF HUSBAND OR WIFE Helen Riley |
|--|--|---|

| | | |
|---|---|---|
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes WWI WWII | 16. SOCIAL SECURITY NO. 709 14 9740 | 17. INFORMANT Helen Riley Address Vichy, Mo. |
|---|---|---|

| | | |
|--|--|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis | | INTERVAL BETWEEN ONSET AND DEATH 24 hr |
| 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 (e) | | 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 Jan 1957 to April 23, 1960 and last saw ^{her} him alive on April 22, 1960
Death occurred at 2:00 Pm on the date stated above, and to the best of my knowledge, from the causes stated.

| | | |
|---|---------------------------------|------------------------------------|
| 22a. SIGNATURE (Degree or title) <i>D. Anderson M.D.</i> | 22b. ADDRESS Rolla Mo | 22c. DATE SIGNED 4/24/60 |
|---|---------------------------------|------------------------------------|

| | | | |
|---|-------------------------------|---|---|
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Removal | 23b. DATE 4/24/1960 | 23c. NAME OF CEMETERY OR CREMATORY Mt. Olive Cemetery | 23d. LOCATION (City, town, or county) (State) Kansas City, Missouri |
|---|-------------------------------|---|---|

| | | |
|--|--|--|
| 24. FUNERAL DIRECTOR Carl J. Glenn ADDRESS West 10th. st., Rolla, Mo. | 25. DATE RECD. BY LOCAL REG. Apr. 24, 1960 | 26. REGISTRAR'S SIGNATURE <i>Nedra L. Stoll</i> |
|--|--|--|

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

VS MAY 3 1960

STATEMENT BY LICENSED EMBALMER

APR 28 1960

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 Carl J. Glenn

Licensed Embalmer No. 470

P. O. Address Rella, W.

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.