

RI. DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS SEP 28 1960

-60-034120

STATE FILE NUMBER

Registration District No. 387 Primary Registration District No. 5208 Registrar's No. 8

1. PLACE OF DEATH a. COUNTY <b>CARROLL</b>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) e. STATE <b>Missouri</b> b. COUNTY <b>Carroll</b>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>HALE</b>		Length of stay in 1b	c. CITY OR TOWN <b>Hale, RFD</b>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Home, 4 Miles S/E</b>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>Farm Home S/E 4 miles</b>		Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>EDWARD</b> Middle <b>GIBSON</b> Last <b>RILEY</b>			4. DATE OF DEATH Month <b>Sept.</b> Day <b>21</b> Year <b>1960</b>		
5. SEX <b>M</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>11/12/1885</b>	9. AGE (last birthday) <b>74</b>	IF UNDER 1 YEAR Months <b>10</b> Days <b>9</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Stock Farm</b>	11. BIRTHPLACE (City and state or country) <b>Hale, Missouri</b>	12. CITIZEN OF WHAT COUNTRY <b>U. S. A.</b>	
13a. FATHER'S NAME <b>George W. Riley</b>		13b. MOTHER'S MAIDEN NAME <b>Mary E. McLaughlin</b>		14. NAME OF HUSBAND OR WIFE <b>Viola (White) 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>NO</b>	17. INFORMANT Address <b>Mrs Chas. D.ugherty, Tina, Missouri</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>Chronic myocarditis</b>					INTERVAL BETWEEN ONSET AND DEATH <b>?</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>arteriosclerosis</b>					<b>?</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) <b>(1) old cerebrovascular accident (2) Abdominal Aneurysm</b>				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 <b>2:00 A.M.</b> Month, Day, Year <b>Aug 31-60</b>					
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" 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>Aug 31-60</b> to <b>Sept 21-60</b> and last saw him alive on <b>Sept 10-60</b> . Death occurred at <b>2:00 A.M.</b> m on the date stated above, and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) <b>Joseph T. Gale M.D.</b>			22b. ADDRESS <b>Chillicothe, Mo.</b>		22c. DATE SIGNED <b>9-23-60</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>9/23/1960</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Hale Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Hale, Missouri</b>	
24. FUNERAL DIRECTOR <b>Clifford W. Austin F-H Hale, Mo.</b>		25. DATE RECD. BY LOCAL REG. <b>Sept. 23, 1960</b>	26. REGISTRAR'S SIGNATURE <b>Mrs Rex Henderson</b>		

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

JAN 24 1961.

**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 Clifford W. Austin

Clifford W. Austin,  
Licensed Embalmer No. #3233

P. O. Address Tina, Miss

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to do so 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.