

DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-042238

LED VS NOV 17 1960

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 5487 STATE FILE NUMBER

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| 1. PLACE OF DEATH a. COUNTY Jackson | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Jackson | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Kansas City | | Length of stay in lb Lifetime | c. CITY OR TOWN Kansas City |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 431 East 79th Street | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | d. STREET ADDRESS (If outside, give location) 431 East 79 Street |
| | | Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | |

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| 3. NAME OF DECEASED (Type or print) First Alexander Middle L. Last Riley | 4. DATE OF DEATH Month Oct Day 28 Year 1960 |
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| 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 5-12-1892 | 9. AGE (last birthday) 68 | IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> | IF UNDER 24 HR Hours <input type="checkbox"/> Min. <input type="checkbox"/> |
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| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Sales Consultant | 10b. KIND OF BUSINESS OR INDUSTRY Printing | 11. BIRTHPLACE (City and state or country) Kansas City MO | 12. CITIZEN OF WHAT COUNTRY U.S. |
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| 13a. FATHER'S NAME Alexander L. Riley | 13b. MOTHER'S MAIDEN NAME Henrietta Hawk | 14. NAME OF HUSBAND OR WIFE Louella Mosby Riley |
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| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes W.W.No. I | 16. SOCIAL SECURITY NO. 486-07-3245 | 17. INFORMANT Louella M. Riley, Kansas City Mo. | Address |
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| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic myeloid leukemia | | INTERVAL BETWEEN ONSET AND DEATH |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. | DUE TO (b) | |
| | DUE TO (c) | |

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| 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. <input type="checkbox"/> Yes <input type="checkbox"/> N. <input type="checkbox"/> Unknown |
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| 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.) |
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| 20c. TIME OF INJURY Hour <input type="checkbox"/> a.m. <input type="checkbox"/> p.m. | Month, Day, Year |
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| 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 |
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21. I attended the deceased from _____ to _____ and last saw ^{him} ~~her~~ alive on _____
Death occurred at **11.55** **P.** on the date stated above, and to the best of my knowledge, from the causes stated.

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| 22a. SIGNATURE (Degree or title) Hugh H. Owens | 22b. ADDRESS 152 Union Station | 22c. DATE SIGNED 10-31-60 |
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| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 23b. DATE Oct. 31-60 | 23c. NAME OF CEMETERY OR CREMATORY Mt. Moriah | 23d. LOCATION (City, town, or county) Kansas City Mo. |
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| 24. FUNERAL DIRECTOR Wagner Funeral Home K.C. Mo | ADDRESS | 25. DATE RECD. BY LOCAL REG. 10-31-60 | 26. REGISTRAR'S SIGNATURE H. L. Dwyer |
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BY AFFIDAVIT OF MEDICAL CERTIFICATION Hugh H. Owens MD

STATEMENT BY LICENSED EMBALMER

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

Student _____
Signature of Student Embalmer

Signed Alvin R. Haunack

Licensed Embalmer No. 415

P. O. Address N. C. 7

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