ISSOURI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

=61=023090
STATE FILE NUMBER

AMENDED

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 5699

FILED JUN 26 1961

DATE AMENDED 9-

INSTEAD OF

SHOULD READ

ITEM NO.

BY AFFIDAVIT OF DOCUMENT

1. PLACE OF DEATH
a. COUNTY
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: St. Louis
Length of stay in 1b
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION: Homer G. Phillips
Inside Limits: Yes ☐ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Missouri b. COUNTY
c. CITY OR TOWN: St. Louis
Inside Limits: Yes ☐ No ☐
d. STREET ADDRESS (If outside, give location): 5319 Theodosia
Reside on Farm: Yes ☐ No ☐

3. NAME OF DECEASED (Type or print): First: Guy; Middle; Last: Riley
4. DATE OF DEATH: Month 6; Day 16; Year 61
5. SEX: Male
6. COLOR OR RACE: Negro
7. Married ☒ Never Married ☐ Widowed ☐ Divorced ☐
8. DATE OF BIRTH: 8/19/87
9. AGE (last birthday): 73
IF UNDER 1 YEAR: Months; Days
IF UNDER 24 HR: Hours; Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired
10b. KIND OF BUSINESS OR INDUSTRY: Railroad
11. BIRTHPLACE (City and state or country): Talahashi, Miss.
12. CITIZEN OF WHAT COUNTRY: U.S.A.
13a. FATHER'S NAME: Joe Enix Riley
13b. MOTHER'S MAIDEN NAME: Unknown
14. NAME OF HUSBAND OR WIFE: Leatha Riley
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no
(If yes, give war or dates of service): --
16. SOCIAL SECURITY NO.: --
17. INFORMANT: Katie B. Riley, 5319 Theodosia
Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral Thrombosis due to Arteriosclerosis — INTERVAL BETWEEN ONSET AND DEATH: Undet.
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b):
DUE TO (c): 332x
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a): Chronic Brain Syndrome due to Cerebral Arteriosclerosis
PART III. If deceased was female was there a pregnancy in last 90 days. ☐ Yes ☐ No ☐ Unknown

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐
20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐
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 ☐ NOT WHILE AT WORK ☐
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 6-14-61, to 6-16-61 and last saw her/him alive on 6-16-61
Death occurred at 2:00 a.m. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title): Sydney R. Frazier
22b. ADDRESS: 2601 N. Whittier
22c. DATE SIGNED: 6-16-61

23a. BURIAL, CREMATION, REMOVAL (Specify): Removal
23b. DATE: 6/20/61
23c. NAME OF CEMETERY OR CREMATORY: Oakdale Cemetery
23d. LOCATION (City, town, or county) (State): St. Louis County, Mo.

24. FUNERAL DIRECTOR: Charles J. Gates
ADDRESS: 4107 Finney
25. DATE REC'D BY LOCAL REG.: JUN 19 1961
26. REGISTRAR'S SIGNATURE: Earl Smith, M.D.

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 Guifan Swan

Licensed Embalmer No. 4580

P. O. Address 4107 Finney

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.