ISSOURI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

RTMENT OF PUBLIC HEALTH AND WELFARE

-61-031681
STATE FILE NUMBER

AMENDED

Registration District No. 374 Primary Registration District No. 2150 Registrar's No. 17

FILED SEP 13 1961

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

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

3. NAME OF DECEASED (Type or print): First Robert Middle Henry Last Riley
4. DATE OF DEATH: Month August Day 31, Year 1961
5. SEX: Male
6. COLOR OR RACE: White
7. Married ☒ Never Married ☐ Widowed ☐ Divorced ☐
8. DATE OF BIRTH: 8-25-1887
9. AGE (last birthday): 74
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): Dealer and owner
10b. KIND OF BUSINESS OR INDUSTRY: old iron
11. BIRTHPLACE (City and state or country): Gaynor, Missouri
12. CITIZEN OF WHAT COUNTRY: U. S.
13a. FATHER'S NAME: Amos L. Riley
13b. MOTHER'S MAIDEN NAME: Mary Alice Cox
14. NAME OF HUSBAND OR WIFE: Dixie Lue Riley
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): no
16. SOCIAL SECURITY NO.: 440-500-251
17. INFORMANT Address: Mrs. Dixie Riley - Sheridan, Missouri

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): Carcinoma Prostate
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b): metastic to Liver
DUE TO (c):
INTERVAL BETWEEN ONSET AND DEATH:

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. ☐ 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 Aug 4 61 a to Aug 31 61 and last saw her/him alive on Aug 31-61
Death occurred at 11 30 a m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title): H. G. Porter MD
22b. ADDRESS: Maryville Mo
22c. DATE SIGNED: 9-2-61

23a. BURIAL, CREMATION, REMOVAL (Specify): burial
23b. DATE: 9-3-1961
23c. NAME OF CEMETERY OR CREMATORY: Gaynor Cemetery
23d. LOCATION (City, town, or county) (State): Gaynor, Missouri

24. FUNERAL DIRECTOR ADDRESS: Bill A. Dunlee - Grant City, Mo.
25. DATE RECD. BY LOCAL REG.: Sept. 9, 1961
26. REGISTRAR'S SIGNATURE: Lola E. Dawson

(Licensed Embalmer's Statement on Reverse Side)

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS
ITEM NO. | SHOULD READ | INSTEAD OF | DATE AMENDED
BY AFFIDAVIT OF DOCUMENT

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 Bill A. Dunfe

Licensed Embalmer No. 4908

P. O. Address Grant City

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.