

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-51-031681
STATE FILE NUMBER

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

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

AMENDED
FILED SEP 13 1961

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

| | | | | | |
|---|--|--|--|--|--|
| 3. NAME OF DECEASED (Type or print) First Middle Last Robert Henry Riley | | | 4. DATE OF DEATH Month Day Year August 31, 1961 | | |
|---|--|--|--|--|--|

| | | | | | | |
|-----------------------|----------------------------------|---|--------------------------------------|-------------------------------------|--------------------------------|------------------------------|
| 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 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 | 17. INFORMANT Address Mrs. Dixie Riley - Sheridan, Missouri |
|--|--|

| | | |
|--|--|--|
| 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 DUE TO (b) metastatic 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. <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 Aug 4 61 to Aug 21 61 and last saw him alive on Aug 31 61
Death occurred at 11:30 on the date stated above, and to the best of my knowledge, from the causes stated.

| | | |
|--|------------------------------------|-----------------------------------|
| 22a. SIGNATURE (Name or title) D. P. Porter M.D. | 22b. ADDRESS Mayville 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) Gaynor, Missouri |
|--|------------------------------|--|--|

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

(Licensed Embalmer's Statement on Reverse Side)

AMENDED
DATE AMENDED
INSTEAD OF
DOCUMENT
MEDICAL CERTIFICATION
BY AFFIDAVIT OF
ITEM NO. SHOULD READ

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. Dwyer

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.