

No. 2  
X21492

AUG 14 1940

Registration District No. 198

Primary Registration District No. 3011

Registrar's No. 105

1. PLACE OF DEATH:

(a) County Clay  
(b) City or town Excelsior Springs  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: Excelsior Hospital  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 1 day  
(Specify whether  
In this community 3 years  
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Texas (b) County \_\_\_\_\_  
City or town Denison  
(If outside city or town limits, write "RURAL")  
(d) Street No. 1300 West Murray  
(If rural, give location)  
(e) If foreign born, how long in U. S. A. \_\_\_\_\_ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 6  
year 1940 hour 4 minute 45 P. M.  
21. I hereby certify that I attended the deceased from June 30  
\_\_\_\_\_ 1940, to July 6 \_\_\_\_\_ 1940  
that I last saw him alive on July 6 \_\_\_\_\_ 1940  
and that death occurred on the date and hour stated above.

3. (a) PRINT FULL NAME Patrick Riley 407  
3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Widow  
6. (b) Name of husband or wife Susan Craden 6. (c) Age of husband or wife if alive 66 years  
7. Birth date of deceased Dec 5 1864  
(Month) (Day) (Year)

8. AGE: Years 75 Months 7 Days 1 If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_

9. Birthplace Brooklyn New York  
(City, town, or county) (State or foreign country)

10. Usual occupation Railroad Brakeman

11. Industry or business Railroad

12. Name John Joseph Riley  
13. Birthplace Ireland  
(City, town, or county) (State or foreign country)  
14. Maiden name Sarah M. Ginn  
15. Birthplace Ireland  
(City, town, or county) (State or foreign country)

16. (a) Informant Dennis P. Lige

(b) Address Denison Texas

17. (a) Denison Texas (b) Date thereof 7-7-40  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Denison Texas

18. (a) Signature of funeral director Blair M. ...  
(b) Address Excelsior Springs Mo.

19. (a) 718 11940 (b) Mr. Red M. Cracker  
(Date received by registrar) (Registrar's signature)

Immediate cause of death Carcinoma of intestinal tract - Cecum + stomach

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

PHYSICIAN \_\_\_\_\_  
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) \_\_\_\_\_

(b) Date of occurrence \_\_\_\_\_

(c) Where did injury occur? \_\_\_\_\_ (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? 180  
While at work? \_\_\_\_\_ (Specify type of place) (e) Means of injury \_\_\_\_\_

23. Signature Denton V. Dawson (M. D. or other) \_\_\_\_\_  
Address Excelsior Springs Mo. Date signed 7-6-40

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

4  
2  
1

Date Filed 8-8-40  
District File Number  
District Health Officer No. 8  
RECEIVED

**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.....

Walter Barker

Registered Apprentice No. 228

working under my personal supervision.

Signed Clarence Richard

Licensed Embalmer No. 2751

P. O. Address Excelsior Spgs

**Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)**

If this body is not embalmed, above space should be left blank.

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 24899  
Registrar's No. 105-

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS  
Registration District No. 198 Primary Registration District No. 3011

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:  
(a) County Clay  
(b) City or town Excelsior Spg - mo  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether)  
In this community \_\_\_\_\_ (Specify whether)  
years, months or days

3. (a) PRINT FULL NAME Patricia Riley  
3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex m 5. Color or race w  
6. (a) Single, widow, married, divorced Div  
6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband, or wife, if alive \_\_\_\_\_ years  
7. Birth date of deceased \_\_\_\_\_ (Month) \_\_\_\_\_ (Day) \_\_\_\_\_ (Year)

8. AGE: Years 75 Months 7 Days 1 If less than one year \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace \_\_\_\_\_ (City, town, or county) \_\_\_\_\_ (State or foreign country)

10. Usual occupation \_\_\_\_\_

11. Industry or business \_\_\_\_\_

12. Name \_\_\_\_\_

13. Birthplace \_\_\_\_\_ (City, town, or county) \_\_\_\_\_ (State or foreign country)

14. Maiden name \_\_\_\_\_

15. Birthplace \_\_\_\_\_ (City, town, or county) \_\_\_\_\_ (State or foreign country)

16. (a) Informant \_\_\_\_\_

(b) Address \_\_\_\_\_

17. (a) \_\_\_\_\_ (b) Date thereof \_\_\_\_\_ (Month) \_\_\_\_\_ (Day) \_\_\_\_\_ (Year)

(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_

(b) Address \_\_\_\_\_

19. (a) \_\_\_\_\_ (b) \_\_\_\_\_ (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:  
(a) State \_\_\_\_\_ (b) County \_\_\_\_\_  
(c) City or town \_\_\_\_\_ (If outside city or town limits write "RURAL")  
(d) Street No. \_\_\_\_\_ (If rural, give location)  
(e) If foreign born, how long in U. S. A.? \_\_\_\_\_ years

20. DATE OF DEATH: Month July day 6 year 1970 hour \_\_\_\_\_ minute \_\_\_\_\_ M.  
21. I hereby certify that I attended the deceased from \_\_\_\_\_ 19 \_\_\_\_\_ to \_\_\_\_\_ 19 \_\_\_\_\_ that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_ 19 \_\_\_\_\_ and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Hemorrhage  
Intestinal tract Cecum + Stomach  
Due to Fat embolism  
Due to Cerebral hemorrhage  
Other conditions (Include pregnancy within 3 months of death) unable to determine  
Major findings: acute pneumonia  
Of autopsy none 46

22. If death was due to external causes, fill in the following:  
(a) Accident, suicide, or homicide (specify) \_\_\_\_\_  
(b) Date of occurrence \_\_\_\_\_  
(c) Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)  
(d) Did injury occur in or about home, on farm, in industrial place, in public place? \_\_\_\_\_  
While at work \_\_\_\_\_ (Specify type of place) (r) Means of injury \_\_\_\_\_  
23. Signature Lester V. Dawson (M. D. or other) \_\_\_\_\_  
Address Excelsior Spg Date signed \_\_\_\_\_

SUPPLEMENTARY

PHYSICIAN  
Underline the cause to which death should be charged statistically.

