V. S. No. 2
100M—2-43
Rev. 5-17-39
I X35697

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED MAR 13 1945

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 6643

Registration District No. 204 Primary Registration District No. 3043 Registrar's No. 39

1. PLACE OF DEATH:

(a) County Marion

(b) City or town Hannibal
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: Levering Hosp.
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution ..... (Specify whether
In this community ..... years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Marion

(c) City or town Hannibal
(If outside city or town limits, write "RURAL")

(d) Street No. 115 North Griffith
(If rural, give location)

(e) Citizen of foreign country? ..... (Yes or No)

If yes, name country .....

3. (a) PRINT FULL NAME James T. Riney

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 Married

6. (b) Name of husband or wife Mrs. Neslie Riney

6. (c) Age of husband or wife if alive 73 years

7. Birth date of deceased January 14, 1870 (Month) (Day) (Year)

8. AGE: Years 75 Months - Days 14 If less than one day ..... hr. ..... min.

9. Birthplace Stylesville Iowa (City, town, or county) (State or foreign country)

10. Usual occupation Retired

11. Industry or business Burlington

FATHER
12. Name Thomas Leo Riney
13. Birthplace Kentucky (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Mary Jane Parsons
15. Birthplace Kentucky (City, town, or county) (State or foreign country)

16. (a) Informant Mrs. James L. Riney

(b) Address 115 North Griffith

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/30/45 (Month) (Day) (Year)

(c) Place: burial or cremation Vandalia Missouri

18. (a) Signature of funeral director Wm. M. Smith

(b) Address 902 Broadway Hannibal Mo

19. (a) 2-3-45 (Date received local registrar) (b) R. H. Connor (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month January day 28 year 1945 hour 5 minute 40 P. M.

21. I hereby certify that I attended the deceased from Jan. 18, 1945, to Jan. 28, 1945; that I last saw him alive on Jan 28, 1945; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Carcinoma of head of pancreas	6 mo
~~Due to~~ Complete obstruction common bile duct	2 mo
~~Due to~~	
Other conditions (Include pregnancy within 3 months of death)	

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Major findings:
Of operations Same —

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? — (Specify type of place)

While at work? — (e) Means of injury —

23. Signature Howard B. Sinclair (M. D. or other) MD

Address Hannibal Mo Date signed 2-2-45

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(Licensed Embalmer's Statement on Reverse Side)

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.....

....., Registered Apprentice No.....,

working under my personal supervision.

Signed George T. Bond

Licensed Embalmer No. 4373

P. O. Address Hannibal Missouri

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 this body is not embalmed, fact should be so stated above.