

7. S. No. 2
DOM-5-43
ev. 5-17-39
I X36671

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

42728

State File No. _____

FILED DEC 16 1947

Registration District No. 310

Primary Registration District No. 3058

Registrar's No. 208

92
9
3

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

1. PLACE OF DEATH:

(a) County St. Charles

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

(c) Name of hospital or institution: St. Joseph Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 8 days
Specify whether

In this community _____
years, months or days

3. (a) PRINT FULL NAME ALBERT C. RIFFLE

3. (b) If veteran, name war None

3. (c) Social Security No. None

4. Sex F Color or race W

6. (a) Single, widowed, married, divorced Divorced

6. (b) Name of husband or wife _____

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

7. Birth date of deceased: Oct 10 1878
(Month) (Day) (Year)

8. AGE: Years 69 Months 1 Days 1
If less than one day hr. min.

9. Birthplace Foley Missouri
(City, town, or county) (State or foreign country)

10. Usual occupation Railroad Employee

MOTHER FATHER

11. Industry or business _____

12. Name Daniel S. Riffle

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

14. Maiden name Nancy Carter

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

16. (a) Informant Lee Riffle

(b) Address Troy Mo.

17. (a) Burial (b) Date thereof: Nov 13, 47
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Troy Cemetery

18. (a) Signature of funeral director Wayne M. Bay

(b) Address Troy Mo.

19. (a) 1228-47 (b) Nancy Hamilton
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Lincoln

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

(d) Street No. _____
(If rural, give location)

(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov day 11
year 1947 hour 12 minute 00 P.M.

21. I hereby certify that I attended the deceased from Nov 8
_____, 1947, to Nov 11, 1947
that I last saw him alive on Nov 11, 1947
and that death occurred on the date and hour stated above.

Immediate cause of death Pulmonary embolism

Due to Prostatectomy

Due to _____

Other conditions 37 B
(Include pregnancy within 3 months of death)

Major findings: Benign hypertrophy
Of operations Prostate

Of autopsy _____

Duration _____

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? _____

While at work? _____
(Specify type of place) (e) Means of injury _____

23. Signature W. Schuchman (M. D. or other) MD
Address St. Charles, Mo Date signed 11/14/47

RECEIVED
District Health Officer No. 9,
District File Number
Date Filed 12-13-17

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..... *Wayne Mc Coy*
Licensed Embalmer No. *2586*
P. O. Address..... *Troy Mo.*

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.