

FILED SEP 17 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 29546

BIRTH NO. _____		REG. DIST. NO. <u>53</u>		PRIMARY REG. DIST. NO. <u>3010</u>		Registrar's No. <u>294</u>	
1. PLACE OF DEATH a. COUNTY <u>Cape Girardeau</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Perry</u>			
b. CITY (If outside corporate limits, write RURAL and give OR TOWN <u>Cape Girardeau Mo.</u>)		c. LENGTH OF STAY (in this place) <u>6 Days</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Lithium Mo</u>			
d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION <u>St. Francis Hospital</u>				d. STREET ADDRESS (If rural, give location)			
3. NAME OF DECEASED (Type or Print) a. (First) <u>Variece</u>		b. (Middle) <u>J.</u>		c. (Last) <u>Riney</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>August 29 1949</u>	
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>		8. DATE OF BIRTH <u>April 12 1873</u>	
9. AGE (In years last birthday) <u>76</u>		IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 4 HRS. Hours _____ Min. _____			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Perry Co. Mo.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13a. FATHER'S NAME <u>Thomas E. Riney</u>			13b. MOTHER'S MAIDEN NAME <u>Mary Ann Stewart</u>			14. NAME OF HUSBAND OR WIFE. <u>Lena Riney</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <u>None</u>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Lena Riney Lithium Mo.</u>			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) <i>*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.</i>		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Coronary Embolism</u> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Thrombo-embolites</u> DUE TO (c) <u>Prostatic Surgery</u> II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Prostatic Hypertrophy</u>					INTERVAL BETWEEN ONSET AND DEATH <u>5 min</u> <u>2 days</u> <u>3 days</u> <u>610X</u>
19a. DATE OF OPERATION <u>8-26-49</u>		19b. MAJOR FINDINGS OF OPERATION <u>Prostatic Hypertrophy</u>					20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>8-25-49</u> to <u>8-24, 1949</u> that I last saw the deceased alive on <u>8-24, 1949</u> and that death occurred at <u>12:4 p.m.</u> , from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) <u>Dr. S. H. ... M.D.</u>			23b. ADDRESS <u>Carl Guardian MW</u>		23c. DATE SIGNED <u>9-6-49</u>		
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>Aug. 31 1949</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Mt. Hope Cemetery</u>		24d. LOCATION (City, town, or county) (State) <u>Perryville Mo.</u>	
DATE REC'D BY LOCAL REG. <u>9-6-1949</u>		REGISTRAR'S SIGNATURE <u>T. C. Summers</u>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Young & Sons Perryville Mo.</u>			

(Licensed Embalmer's Statement on Reverse Side)

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

RECEIVED 9-12-49
Public Health Officer No. 4
District File Number 949-119
Date Filed

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
Student Embalmer

Signed *Charles H. King*

Licensed Embalmer No. 2185

P.O. Address *Bayville, Va.*

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.