

FILED OCT 4 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 31390

BIRTH NO. _____ REG. DIST. NO. 294 PRIMARY REG. DIST. NO. 305 Registrar's No. 235

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

1. PLACE OF DEATH a. COUNTY <u>Randolph</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Randolph</u>	
b. CITY OR TOWN <u>Moberly</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Rt. 4 Clark, Mo 0880</u>	
c. LENGTH OF STAY (In this place) <u>8 hrs</u>		d. STREET ADDRESS (If rural, give location) <u>West of Clark, Mo</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>McBarnick Osteopathic Hospital</u>			

3. NAME OF DECEASED a. (First) <u>William</u> b. (Middle) <u>O</u> c. (Last) <u>Riley</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>Sept 24 1950</u>		
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED <u>Married</u>	
8. DATE OF BIRTH <u>Sept 8-1896</u>		9. AGE (In years last birthday) <u>54</u>		10. IF UNDER 1 YEAR <u>0</u> IF UNDER 4 Wks. <u>16</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>Lagonda Missouri</u>	
12. CITIZEN OF WHAT COUNTRY <u>U.S.</u>		13a. FATHER'S NAME <u>P.J. Riley</u>			
13b. MOTHER'S MAIDEN NAME <u>Sarah Howard</u>		14. NAME OF HUSBAND OR WIFE <u>Leander Riley</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> (If yes, give war or dates of service) <u>Aug 3-1917-June 6-1919</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT'S SIGNATURE OR NAME <u>Leander Riley R. 4 Clark Mo</u>	
17. ADDRESS <u>Mo</u>					

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)		MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* <u>Hypostatic Pneumonia Double Lobar</u>		ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Myocardial Degeneration</u>			1917	
*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		DUE TO (c)				
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.					4 222	
19a. DATE OF OPERATION <u>None</u>		19b. MAJOR FINDINGS OF OPERATION <input checked="" type="checkbox"/>			20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	

21a. ACCIDENT SUICIDE HOMICIDE (Specify) <input checked="" type="checkbox"/>		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>None</u>		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) <u>Mo</u>	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) <u>None</u>		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>None</u>	

22. I hereby certify that I attended the deceased from Sept 1st, 1941, to Sept 24, 1950, that I last saw the deceased alive on Sept 24, 1950, and that death occurred at 900 m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <u>Leander Riley M.D.</u>		23b. ADDRESS <u>203 1/2 N. Clark Moberly Mo</u>		23c. DATE SIGNED <u>9/25/50</u>	
24a. BURIAL (CREMATION, REMOVAL) (Specify) <u>Burial</u>		24b. DATE <u>Sept. 26-1950</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Halloway</u>	
24d. LOCATION (City, town, or county) (State) <u>Randolph Co. Mo</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Paul William Love</u> ADDRESS <u>Barnes & Booth Stagers Mo.</u>			
DATE REC'D BY LOCAL REG. <u>9-26-50</u>		REGISTRAR'S SIGNATURE <u>Paul William Love</u>			

7/25/50
1950

OCT 18 1950

Date Received: **OCT 2 1950**
DISTRICT HEALTH OFFICE #
District File Number *10-5*
Date Filed: OCT 3 **1950**

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.....

.....
working under my personal supervision.

Student Embalmer No.....

Signed..... *W. Boothe*

Signed.....

Student Embalmer

Licensed Embalmer No. *4087*

P. O. Address *Sturgeon - Md*

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.