

FILED NOV 18 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **36968**
Registrar's No. **4570**

BIRTH NO. _____ REG. DIST. NO. 149 PRIMARY REG. DIST. NO. Lee2 Registrar's No. 4570

1. PLACE OF DEATH a. COUNTY Jackson		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY Jackson	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Kansas City, Mo.		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Kansas City, Mo.	
d. FULL NAME OF HOSPITAL OR INSTITUTION Home 3121 Garfield		d. STREET ADDRESS (If rural, give location) 3121 Garfield	

3. NAME OF DECEASED (Type or Print) a. (First) Elizabeth		b. (Middle) M.		c. (Last) Child		4. DATE OF DEATH (Month) (Day) (Year) Oct. 27, 50.	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widow		8. DATE OF BIRTH Sept. 16, 1861		9. AGE (In years last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 89 Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housekeeper		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Orrick, Mo.		12. CITIZEN OF WHAT COUNTRY? USA	

13a. FATHER'S NAME Andrew Jackson Riffe		13b. MOTHER'S MAIDEN NAME Angeline Dorton		14. NAME OF HUSBAND OR WIFE Jacob T. Child	
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. none		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Blanche Williams Orrick, Mo.	
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Myocardial Degeneration		INTERVAL BETWEEN ONSET AND DEATH 4 1/2
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.		DUE TO (b) Arterio sclerosis		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		DUE TO (c)		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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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)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
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22. I hereby certify that I attended the deceased from **Oct 9, 1950**, to **Oct 27, 1950**, that I last saw the deceased alive on **Oct 26, 1950**, and that death occurred at **1-a.m.**, from the causes and on the date stated above.

23a. SIGNATURE G.C. Remley	(Degree or title) MD	23b. ADDRESS 832 Argyle Bldg	23c. DATE SIGNED 10-28-50
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24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE Oct. 28, 1950	24c. NAME OF CEMETERY OR CREMATORY South Point	24d. LOCATION (City, town, or county) (State) 2 Mi E. Orrick, Mo.
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DATE REC'D BY LOCAL REG. 10-31-50	REGISTRAR'S SIGNATURE Thereldine Holmes	25. FUNERAL DIRECTOR'S SIGNATURE B. W. Good	ADDRESS Orrick, Mo.
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(Licensed Embalmer's Statement on Reverse Side)

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

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 _____

Self

Student Embalmer No. _____

working under my personal supervision.

Student

Student Embalmer

Signed *Victor E. Laming* _____

Licensed Embalmer No. *2896* _____

P. O. Address *Liberty, 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.