

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **1440**  
**189**

FILED FEB 6 1956  
BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 149 PRIMARY REG. DIST. NO. 1002 Registrar's No. \_\_\_\_\_

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|--|--|--|---|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Jackson</b>  |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>a. STATE <b>Missouri</b> b. COUNTY <b>Jackson</b> |   |
| b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>Kansas City</b>                                      |  | c. CITY OR TOWN <b>Kansas City</b>   | d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |
| c. LENGTH OF STAY (in this place) <b>Years</b>   |  | STREET ADDRESS (If rural, give location) <b>Home 5322 Forest</b>   |   |
| d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION <b>Home 5322 Forest</b> |  |  |   |

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|--|-------------------------------|--|--|--|
| 3. NAME OF DECEASED (Type or Print) <b>SARAH</b>   | a. (First)                    | b. (Middle) <b>JANE</b>  | c. (Last) <b>RILEY</b>   | 4. DATE OF DEATH (Month) (Day) (Year) <b>1 13 56</b> |
| 5. SEX <b>Female</b>   | 6. COLOR OR RACE <b>White</b> | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Single</b> | 8. DATE OF BIRTH <b>3-28-1876</b>  | 9. AGE (In years last birthday) <b>79</b>            |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Secretary Retired</b> |                               | 10b. KIND OF BUSINESS OR INDUSTRY <b>Western Salt Co.</b>            | 11. BIRTHPLACE (City and State or Foreign Country) <b>P Paola, Kans.</b> | 12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>           |

|   |   |   |
|---|---|---|
| 13a. FATHER'S NAME <b>Hugh Riley</b>  | 13b. MOTHER'S MAIDEN NAME <b>Margaret McCorrick</b> | 14. NAME OF HUSBAND OR WIFE <b>none</b>               |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give no. or date of service) <b>no</b> | 16. SOCIAL SECURITY NO. <b>none</b>                 | 17. INFORMANT'S SIGNATURE OR NAME _____ ADDRESS _____ |

|   |  |             |                                  |
|---|--|-------------|----------------------------------|
| 18. CAUSE OF DEATH<br>Enter only one cause per line for (a), (b), and (c)<br><br>*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death. | MEDICAL CERTIFICATION  |             | INTERVAL BETWEEN ONSET AND DEATH |
|   | I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Cardiac Embolism</b>                   |             |                                  |
|   | ANTECEDENT CAUSES<br>DUE TO (b) <b>Many small strokes</b><br>DUE TO (c) <b>arterio-sclerosis</b> |             |                                  |
| II. OTHER SIGNIFICANT CONDITIONS<br>Conditions contributing to the death but not related to the disease or condition causing death.   |  | <b>332X</b> |                                  |

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|--|--|--|
| 19a. DATE OF OPERATION _____                             | 19b. MAJOR FINDINGS OF OPERATION _____   | 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) <b>Kansas City, Jackson, Mo</b>  |
| 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? _____   |

22. I hereby certify that I attended the deceased from \_\_\_\_\_, 1947, to 1-13, 1956, that I last saw the deceased alive on 1-13, 1956, and that death occurred at 4 P m., from the causes and on the date stated above.

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|--|--|--|
| 23a. SIGNATURE <b>James C. Walker M.D.</b> (Degree or title)       | 23b. ADDRESS <b>318 Prof. Bldg K.P. Ho</b> | 23c. DATE SIGNED <b>1-14-56</b>                      |
| 24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>           | 24b. DATE <b>1-16-1956</b>                 | 24c. NAME OF CEMETERY OR CREMATORY <b>Holy Cross</b> |
| 24d. LOCATION (City, town, or county) (State) <b>Paola, Kansas</b> |  |  |

|   |  |  |
|---|--|--|
| DATE REC'D BY LOCAL REG. <b>1-14-56</b> | REGISTRAR'S SIGNATURE <b>newa minshall</b> | 25. FUNERAL DIRECTOR'S SIGNATURE <b>Melody-McGilley-Eylar</b> ADDRESS <b>1800 E. Linwood</b> |
|---|--|--|

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

Dr. James  
Prof.  
HAI-6

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.....  
Signature of Student Embalmer

Signed *James E. Hackleman*

Licensed Embalmer No. 4573

P. O. Address *K. C. 5th*

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.