

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-028967
STATE FILE NUMBER

Registration District No. 141 Primary Registration District No. 3025 Registrar's No. 56
FILED SEP 2 1958

1. PLACE OF DEATH a. COUNTY <u>HOWELL</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MO.</u> b. COUNTY <u>HOWELL</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>WEST PLAINS</u>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>WEST PLAINS</u> <u>0410</u>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>STOLL SURGICAL</u>		Length of stay in lb <u>5th DAYS</u>	d. STREET ADDRESS (If outside, give location) <u>CLEVELAND AVE.</u>
		Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First <u>JOHN</u> Middle <u>BENT</u> Last <u>RILEY</u>	4. DATE OF DEATH Month <u>AUG</u> Day <u>13</u> Year <u>58</u>
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5. SEX <u>M</u> <u>C</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11/4/1882</u>	9. AGE (In years last birthday) <u>75</u>	IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u>	IF UNDER 24 HRS. Hours <u>0</u> Min. <u>0</u>
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>SAW MILL OWNER</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>SAW MILL</u>	11. BIRTHPLACE (City and state or country) <u>DOUGLAS COUNTY, MO.</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
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13a. FATHER'S NAME <u>ROBERT RILEY</u>	13b. MOTHER'S MAIDEN NAME <u>SARAH (unk)</u>	14. NAME OF HUSBAND OR WIFE <u>DECEASED</u>
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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) <u>NONE</u>	16. SOCIAL SECURITY NO. <u>NONE</u>	17. INFORMANT Address <u>LEWIS RILEY WEST PLAINS, MO.</u>
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>Arteriosclerosis, senile</u>	
	DUE TO (c) <u>331X</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>

20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)
20c. TIME OF INJURY Hour <u>5:30</u> Month, Day, Year <u>PM 8-13-58</u> a.m. p.m.	

20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION <u>West Plains Mo</u>	COUNTY <u>MO</u>	STATE
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21. I attended the deceased from 8-8-58 to 8-13-58 and last saw her alive on 8-13-58
Death occurred at 5:30 PM on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <u>JOB Stoll M.D.</u>	(Degree or title)	22b. ADDRESS <u>West Plains Mo</u>	22c. DATE SIGNED <u>8/26/58</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE <u>8/16/58</u>	23c. NAME OF CEMETERY OR CREMATORY <u>SWESTON</u>	23d. LOCATION (City, town, or county) (State) <u>DOMA, MO.</u>
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24. FUNERAL DIRECTOR <u>ROBERTSONS</u>	ADDRESS <u>WEST PLAINS, MO</u>	25. DATE RECD. BY LOCAL REG. <u>8-29-58</u>	26. REGISTRAR'S SIGNATURE <u>Beatrice Cook</u>
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All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

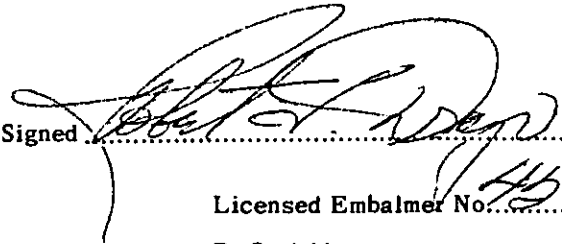
MEDICAL CERTIFICATION

179 C

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 
Licensed Embalmer No. 45717
P. O. Address

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.