

WRITE PLAINLY, WITH UNFADING INK

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

PLACE OF DEATH

County Morris
 Township Jackson
 or
 Village _____
 or
 City _____

Registration District No. 542

File No. _____

Primary Registration District No. 5731

Registered No. 19

FULL NAME Thermon Allen Wiles

[If death occurred in a hospital or institution, give its NAME instead of street and number]

PERSONAL AND STATISTICAL PARTICULARS		
SEX <u>male</u>	COLOR OR RACE <u>white</u>	SINGLE MARRIED <u>yes</u> WIDOWED OR DIVORCED (Write the word)
DATE OF BIRTH <u>Jan 17</u> , 191 <u>5</u> (Month) (Day) (Year)		
AGE <u>2</u> yrs. <u>8</u> mos. <u>24</u> ds.		IF LESS than 1 day, ___ hrs. or ___ min.?
OCCUPATION (a) Trade, profession, or particular kind of work _____ (b) General nature of industry, business, or establishment in which employed (or employer) _____		
BIRTHPLACE (City or town, State or foreign country) <u>Morris Co.</u>		
PARENTS	NAME OF FATHER <u>William T. Wiles</u>	
	BIRTHPLACE OF FATHER (City or town, State or foreign country) <u>Morris Co.</u>	
	MAIDEN NAME OF MOTHER <u>Lula Green</u>	
	BIRTHPLACE OF MOTHER (City or town, State or foreign country) <u>Morris Co.</u>	

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Bert Wiles

(ADDRESS) Vermont

Filed 9/11, 1917 P. S. McGeer
 REGISTRAR

MISSOURI STATE BOARD OF HEALTH BUREAU OF VITAL STATISTICS CERTIFICATE OF DEATH

32454

MEDICAL CERTIFICATE OF DEATH	
DATE OF DEATH <u>Sept 11</u> , 191 <u>7</u> (Month) (Day) (Year)	
I HEREBY CERTIFY, that I attended deceased from <u>Sept 7</u> , 191 <u>7</u> , to <u>Sept 11</u> , 191 <u>7</u> , that I last saw him alive on <u>Sept 11</u> , 191 <u>7</u> , and that death occurred, on the date stated above, at <u>10 a.m.</u>	
The CAUSE OF DEATH* was as follows: <u>Gangrene of foot</u> <u>98%</u>	
(Duration) ___ yrs. ___ mos. ___ ds.	
Contributory (SECONDARY) <u>suppuration</u> (Duration) ___ yrs. ___ mos. ___ ds.	
(Signed) <u>W. A. Gider</u> M. D.	(Address) <u>Bricktown</u>
*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.	
LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) At place of death ___ yrs. ___ mos. ___ ds. In the State ___ yrs. ___ mos. ___ ds.	
Where was disease contracted if not at place of death?	
Former or usual residence	
PLACE OF BURIAL OR REMOVAL <u>Samuel's</u>	DATE OF BURIAL <u>Sept 17</u> , 191 <u>7</u>
UNDERTAKER <u>Wm. M. Cheever</u>	ADDRESS <u>Vermont</u>

PLACE OF DEATH

MISSOURI STATE BOARD OF HEALTH BUREAU OF VITAL STATISTICS CERTIFICATE OF DEATH

Revised United States Standard

County _____

Township _____ or Village _____ or City _____

Registration District No. _____ File No. _____

Primary Registration District No. _____ Registered No. _____

(NO. _____) St. _____ Ward _____

(If death occurred in hospital or institution, give its NAME in full, and number of street and number of block.)

FULL NAME

PERSONAL AND STATISTICAL PARTICULARS

SEX	COLOR OR RACE	SINGLE MARRIED WIDOWED OR DIVORCED (If more than one, write the word)
DATE OF BIRTH		
(Month) _____ (Day) _____ (Year) _____		IF LESS than 1 day, _____ hrs. or _____ min.?
AGE	_____ yrs. _____ mos. _____ ds.	

OCCUPATION _____

(a) Trade, profession, or particular kind of work _____

(b) General nature of industry, business, or establishment in which employed (or employer) _____

BIRTHPLACE _____

(City or town, State or foreign country)

NAME OF FATHER	BIRTHPLACE OF FATHER (City or town, State or foreign country)
MAIDEN NAME OF MOTHER	BIRTHPLACE OF MOTHER (City or town, State or foreign country)

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) _____

(ADDRESS) _____

Filed _____, 191 _____

REGISTRAR

DATE OF DEATH _____

(Month) _____ (Day) _____ (Year) _____

I HEREBY CERTIFY, that I attended deceased _____, 191 _____, to _____, 191 _____, that I last saw him alive on _____, 191 _____, and that death occurred, on the date stated above, at _____

The CAUSE OF DEATH was as follows: _____

Contributory (SECONDARY)

(Duration) _____ yrs. _____ mos.

(Duration) _____ yrs. _____ mos.

(Signed) _____, 191 _____ (Address) _____

*State the Disease Causing Death, or, in deaths from Violent Causes, (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENT RESIDENTS)

At place of death, _____ yrs. _____ mos. _____ ds. State _____ yrs. _____ mos.

Where was disease contracted if not at place of death? _____

Former or usual residence _____

PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
UNDERTAKER	ADDRESS

"Typhoid pneumonia"; Lobar pneumonia; Broncho-pneumonia ("Pneumonia," unqualified, is indefinite);