

NOV 24 1928

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

Do not use this space.

35900

1. PLACE OF DEATH

County North
 Township St. Louis
 City Grant City, Mo. (No. _____)

Registration District No. 903Primary Registration District No. 4845

File No. _____

Registered No. 21

St. _____ Ward _____

2. FULL NAME

William Washington Wiley
 (a) Residence. No. _____ St. _____ Ward _____
 (Usual place of abode)
 (If nonresident give city or town and State)

Length of residence in city or town where death occurred 11 yrs. mos. da. How long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male White Married

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

Virginia Wiley

6. DATE OF BIRTH (MONTH, DAY AND YEAR)

3/23/1831

7. AGE

YEARS

MONTHS

DAYS

If LESS than 1 day, _____ hrs. or _____ min.

97628

8. OCCUPATION OF DECEASED

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

Retired Farmer

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

(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN)

(STATE OR COUNTRY)

Montgomery Co. Illinois

10. NAME OF FATHER

Quilla Wiley

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY)

Unknown Kentucky

12. MAIDEN NAME OF MOTHER

Grantham

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY)

Unknown Unknown

14.

INFORMANT
(Address)J. C. Hill
Grant City Mo.

15.

FILED

Oct 28 John Andrews

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR)

Oct 21 1928

17.

I HEREBY CERTIFY, That I attended deceased from Oct. 17 1928, to Oct. 21 1928, that I last saw him alive on Oct. 21 1928, and that death occurred, on the date stated above, at 9:34 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Pneumonia
Double Pneumonia
Catheter Pneumonia
 (duration) yrs. mos. 5 da.

CONTRIBUTORY (SECONDARY)

10/20/10 (duration) yrs. mos. da.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH

19. DID AN OPERATION PRECEDE DEATH? DATE OF _____

WAS THERE AN AUTOPSY? _____

WHAT TEST CONFIRMED DIAGNOSIS?

(Signed)

B. J. Rose, M. D.

, 19 (Address)

Grant City Mo

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL

DATE OF BURIAL

Isabelle Cemetery Oct. 23 1928

20. UNDERTAKER

ADDRESS

Arch C. Dumble Grant City Mo

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.

THIS IS A PERMANENT RECORD

