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

Do not use this space.

15923

File No. 4395

Registered No.

1. PLACE OF DEATH
County: St. Louis
Registration District No.: 791 ~~1003~~
Primary Registration District No.:
Township:
City: St. Louis (No. City Infirmary St. Ward)

2. FULL NAME: Thomas Liles
(a) Residence. No. 1623 Olive St. St., 13 Ward.
(Usual place of abode) (If nonresident, give city or town and State)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M.
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word): D.

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

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

7. AGE: abt. 64 YEARS; MONTHS ✓; DAYS ✓; If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Salesman 172
(b) General nature of industry, business, or establishment in which employed (or employer): Don't Know
(c) Name of employer: Unknown

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): Tenn.

PARENTS

10. NAME OF FATHER: Michael Liles
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY): Miss.
12. MAIDEN NAME OF MOTHER: Unknown
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY): Unknown

14. INFORMANT: Mrs E. Ellinger
(Address): City Infirmary

15. FILED: 19 Clay C. Stark
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

3

16. DATE OF DEATH (MONTH, DAY AND YEAR): 4-7 1931

17. I HEREBY CERTIFY, That I attended deceased from ....., 19..., to 4-7, 1931, that I last saw him alive on 4-7, 1931, and that death occurred, on the date stated above, at 4-6-31-3:20 p.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Chronic Myocarditis
Essential Hypertension
93C
102
165 (duration) 2 yrs. mos. ds.

CONTRIBUTORY (SECONDARY) Senility
(duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH
DID AN OPERATION PRECEDE DEATH? No. DATE OF
WAS THERE AN AUTOPSY? No.
WHAT TEST CONFIRMED DIAGNOSIS? Physical Findings
(Signed) J. J. Flynn, M. D.
4-7, 1931 (Address) City Hospital

*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: St. Peters — DATE OF BURIAL: April 11 1931

20. UNDERTAKER: Provost Und Co — ADDRESS: 3710 N. Grand

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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.