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.

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

18176
Do not use this space.

1. PLACE OF DEATH
(a) County Clay — Registration District No. 198
(b) ~~Township~~ Fishing River — Primary Registration District No. 3011 — Registered No. 81
(c) or City Excelsior Springs, Mo. (d) Street No. Veterans Administration Facility St.
(If death occurred in Hospital or Institution, write its name instead of street and number)
(e) Length of residence in city or town where death occurred 420 yrs. 1 mos. 5 ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME John Ralph Wiles
(a) Residence, No. 324 East Clayton, Brookfield, Mo. St. Brookfield, Mo.
(Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (*write the word*): Married

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Sept. 11, 1894

7. AGE: Years 45 — Months 8 — Days 8 — If LESS than 1 day, ...hrs. or ....min.

OCCUPATION
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Clerk
9. Industry or business in which work was done, as saw mill, bank, etc. Lumber Company
10. Date deceased last worked at this occupation (month and year) Unknown
11. Total time (years) spent in this occupation Unknown

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Jamesport Missouri

FATHER
13. NAME Thomas Wiles
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Jamesport, Missouri

MOTHER
15. MAIDEN NAME Flora Belle Wiles
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Jamesport Missouri

17. INFORMANT (ADDRESS) Hospital Records

18. ~~BURIAL, CREMATION, OR~~ REMOVAL
PLACE Brookfield, Mo. DATE May 20, 1940

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Claude Prichard Excelsior Springs, Mo.

20. FILED May 19th, 1940 Mrs Rea Crocker Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) May 19, 1940

22. I HEREBY CERTIFY, That I attended deceased from April 14, 1940, to May 19, 1940, I last saw him alive on May 19, 1940. Death is said to have occurred on the date stated above, at 12:35 P.M.
The principal cause of death and related causes of importance were as follows:

	Date of onset
Cardiac Hypertrophy with decompensation and dilatation	

Other contributory causes of importance: Ascites

Name of operation None Date of
What test confirmed diagnosis? Examination and autopsy Was there an autopsy? Yes

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? -- Date of injury, 19
Where did injury occur? --
(Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place. --
Manner of injury --
Nature of injury ---

24. Was disease or injury in any way related to occupation of deceased?
If so, specify Unknown

(Signed) W. A. German, M. D.
(Address) W. A. GERMAN, M.D., Clinical Director
Veterans Administration Facility
~~Excelsior Springs~~, Mo.

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 8,
District File Number
Date Filed 6-4-40

JAN 9 1945

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 Walter Barker, Registered Apprentice No. 228 working under my personal supervision.

Signed Claude Prichard

Licensed Embalmer No. 2757

P. O. Address Excelsior Spgs W

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to com with the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.