

Registration District No. **399**

Primary Registration District No. **1002**

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:

(a) County Jackson  
(b) City or town Kansas City  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
3421 Euclid Avenue **2**  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 55 Years  
(Specify whether years, months or days)

3. (a) PRINT FULL NAME Mr. Joseph Hiram Giles

3. (b) If veteran, name war None 3. (c) Social Security No. None

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Mrs. Mae Annâ Giles 6. (c) Age of husband or wife if alive 56 years

7. Birth date of deceased October 22 1884  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
56 1 24 hr. min.

9. Birthplace Springfield Missouri  
(City, town, or county) (State or foreign country)

10. Usual occupation Supervisor - Retired sev. Yrs.

11. Industry or business Western Union

MOTHER FATHER { 12. Name Frank Giles

13. Birthplace Glens Falls New York  
(City, town, or county) (State or foreign country)

14. Maiden name Anna Elizabeth

15. Birthplace Glens Falls New York  
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Joe H. Giles

(b) Address 3421 Euclid Ave

17. (a) Burial (b) Date thereof Dec. 17, 1940  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Mt. Moriah Mausoleum

18. (a) Signature of funeral director W. H. Newcomer son

(b) Address 1401 Brush Creek Blvd.

19. (a) 12-16-40 (b) M. M. Brown  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson  
(c) City or town Kansas City  
(If outside city or town limits, write "RURAL")  
(d) Street No. 3421 Euclid Avenue  
(If rural, give location)  
(e) If foreign born, how long in U. S. A? - years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec day 15  
year 1940 hour A.M. minute 1:15 A.M.

21. I hereby certify that I attended the deceased from Dec 13 1935 to Dec - 14 1940  
that I last saw him alive on Dec - 14 1940  
and that death occurred on the 15th and hour stated above.

Immediate cause of death Parasitosis  
Shistosoma mellittina

Duration 43 yrs  
18 yrs

Due to

Due to

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations

Of autopsy

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify)

(b) Date of occurrence

(c) Where did injury occur? (City of town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?

While at work? (Specify type of place) (e) Means of injury

23. Signature Paul H. Brown (M. D. optional)  
Address 106 W. 14th St. Kansas City, Mo. Date signed 12/14/40

83-

Mr. Giles

---

---

**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.....

....., Registered Apprentice No.....

working under my personal supervision.

Signed George M. Collier

Licensed Embalmer No. 3839

P. O. Address D.C. Mo.

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

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

State File No. ....

Registration District No. ....

Primary Registration District No. ....

Registrar's No. 4774

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH

(a) County Jackson  
(b) City or town K.C.  
(c) Name of hospital or institution:  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution  
In this community (Specify whether years, months or days)

3. (a) PRINT FULL NAME

Joseph H. Giles

(b) If veteran, name war

3. (c) Social Security No.

4. Sex M

5. Color or race W

6. (a) Single, widowed, married, divorced M

6. (b) Name of husband or wife

6. (c) Age of husband, or wife, if alive

7. Birth date of deceased

(Month) (Day) (Year)

8. AGE:

Years Months Days If less than one day hr. min.

9. Birthplace

(City, town, or county) (State or foreign country)

10. Usual occupation

11. Industry or business

MOTHER FATHER { 12. Name

13. Birthplace

(City, town, or county) (State or foreign country)

14. Maiden name

15. Birthplace

(City, town, or county) (State or foreign country)

16. (a) Informant

(b) Address

17. (a)

(Burial, cremation, or removal)

(b) Date thereof

(Month) (Day) (Year)

(c) Place: burial or cremation

18. (a) Signature of funeral director

(b) Address

19. (a)

(Date received local registrar)

(b)

(Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State (b) County  
(c) City or town (If outside city or town limits write "RURAL")  
(d) Street No. (If rural, give location)  
(e) If foreign born, how long in U. S. A. ? years.

20. DATE OF DEATH Month Dec. day 15 - year 40  
hour minute M.

21. I hereby certify that I attended the deceased from 19 to 19 that I last saw him alive on and that death occurred on the date and hour stated above.

Immediate cause of death

Paresis  
Diabetes Mellitus  
General Paresis of the  
Insane of Hereditary Origin

Major findings:

Of operations

Of autopsy

Jan 24 - 1941  
GG

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify)  
(b) Date of occurrence  
(c) Where did injury occur? (City or town) (County) (State)  
(d) Did injury occur in or about home, or farm, in industrial place, in public place?  
While at work? (Specify type of place) (e) Means of injury

23. Signature Carl H. Brown (M. D. or other)  
Address 106 W. 14th St. Kansas Date signed 1/24/41

SUPPLEMENTARY

S-4138L 1940