

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

35486
Do not use this space.

FILLED NOV 19 1941

1. PLACE OF DEATH

(a) County Marion Registration District No. 1040
 (b) Township Miller Primary Registration District No. 6276
 (c) City 1 (d) Street No. 1 St. 10
 (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 10 yrs. & mos. & ds. (f) How long in U. S., if of foreign birth? 10 yrs. & mos. & ds.

2. PRINT FULL NAME

Nellie Elizabeth Wiles
 (a) Residence, No. 10 St. 10
 (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 Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED Widowed
 (write the word)

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) 1872 May 26

7. AGE YEARS 69 MONTHS 4 DAYS 8
 If LESS than 1 day, 2 hrs. or 2 min.

OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, cooper, etc. Retired Housekeeper
 9. Industry or business in which work was done, as saw mill, bank, etc. home
 10. Date deceased last worked at this occupation (month and year) 1935 11. Total time (years) spent in this occupation 50

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) New Madrid Missouri

FATHER 13. NAME Joe Bellon

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) New Madrid Missouri

MOTHER 15. MAIDEN NAME Unknown

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) New Madrid Missouri

17. INFORMANT (ADDRESS) Mr John Rollins Dixon, Mo

18. BURIAL, CREMATION, OR REMOVAL PLACE Wheeler DATE 10-6-41

19. FUNERAL DIRECTOR (ADDRESS) Fred N. Gillies Dixon Mo

20. FILED 10-100 1941 C. Winkelman Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) October 4, 1941

22. I HEREBY CERTIFY, That I attended deceased from 10/4/41, 1941, to 10/4/41, 1941.

I last saw her alive on 10/4/41, 1941. Death is said to have occurred on the date stated above, at 10 m.

The principal cause of death and related causes of importance were as follows:

Coronary thrombosis Date of onset 10/4/41

Other contributory causes of importance: 94a

Name of operation 1 Date of 10/4/41
 What test confirmed diagnosis? 1 Was there an autopsy? no

23. If death was due to external causes (violence), fill in also the following:
 Accident, suicide, or homicide? 1 Date of injury 10/4/41
 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 1
 Nature of injury 1

24. Was disease of injury in any way related to occupation of deceased? no
 If so, specify 1
 (Signed) Conley Jones M. D.
 (Address) Boonville Town, Mo

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.

STATE DEPARTMENT OF HEALTH

STATEMENT BY LICENSED EMBALMER

I, Paul D Gilbert, Licensed Embalmer No. 2341

hereby certify that the body recorded on the reverse side of this certificate was embalmed by me

10/5/41 L. E.

No. _____ or by _____, Registered Apprentice No. _____
working under my personal supervision.

Signed Paul D Gilbert

Licensed Embalmer No. 2341

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.)

Registration District No. **1040**

Primary Registration District No. **6276**

Registrar's No.

1. PLACE OF DEATH

(a) County **maries**
 (b) City or town **Rural miller twp.**
(If outside city or town limits, write "RURAL" and name of township)
 (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.....
(Specify whether
 In this community.....
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **mo** (b) County **maries**
 (c) City or town **Wixom Rural Miller twp.**
(If outside city or town limits, write "RURAL")
 (d) Street No.....
(If rural, give location)
 (e) Citizen of foreign country?.....
(Yes or No)
 If yes, name country.....

3. (a) PRINT FULL NAME **Nellie E. Wiles**

3. (b) If veteran, name war..... 3. (c) Social Security No.....

4. Sex **F** 5. Color or race **W** 6. (a) Single, widowed, married, divorced **w**

6. (b) Name of husband or wife..... 6. (c) Age of husband or wife if alive..... years

7. Birth date of deceased **may 26**
(Month) (Day) (Year)

8. AGE: Years **69** Months **4** Days **14**
(If less than one day min.)

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

10. Usual occupation.....

11. Industry of business.....

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)..... (b) Date thereof.....
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation.....

18. (a) Signature of funeral director.....

(b) Address.....

19. (a) **10-10-41** (b) **CW Winkelman**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Oct** Day **10** Year **1941** hour..... minute..... M.

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

Due to.....

Due to.....

Other conditions.....
(Include pregnancy within 3 months of death)

Major findings:
 Of operations.....

Of autopsy.....

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, on farm, in industrial place, in public place?
(Specify type of place)

While at work?..... (e) Means of injury.....

23. Signature..... (M. D. or other).....
 Address..... Date signed.....

SUPPLEMENTARY

Duration.....
 PHYSICIAN.....
 Underline the cause to which death should be charged statistically.

WRITE PLAINLY—USE L FADING BLACK INK—MA PERMANENT RECORD

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