

FILED APR 15 1944
Registration District No. 999

Primary Registration District No. 1002

State File No. _____
Registrar's No. 1585

1. PLACE OF DEATH:
(a) County Jackson
(b) City or town Kansas City
(c) Name of hospital or institution:
2414 Benton
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution NO.
In this community 10 days (Specify whether years, months or days)

3. (a) PRINT FULL NAME John Daniel Liles
3. (b) If veteran, name war NO. 3. (c) Social Security No. NO.

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Alice Liles 6. (c) Age of husband or wife if alive unknown years
7. Birth date of deceased April 26 1875
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
68 11 12 hr. min.

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

10. Usual occupation Retired

11. Industry or business no.

12. Name George Liles

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

14. Maiden name Hannah Cooper

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

16. (a) Informant Mrs. Alice Liles

(b) Address Metz, Missouri

17. (a) Removal (Burial, cremation, or removal) (b) Date thereof 4-10-44
(Month) (Day) (Year)

(c) Place: burial or cremation Nevada, Missouri

18. (a) Signature of funeral director Stine & McClure,
3235 Gillham Plaza, K. C., Mo.

19. (a) 4-10-44 (Date received local registrar) (b) N. E. Brown (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. 2414 Benton
(If rural, give location)
(e) Citizen of foreign country? NO. (Yes or No)
If yes, name country X

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 8th
year 1944 hour 1:00 minute 0 M.

21. I hereby certify that I attended the deceased from March 27, 1944 to April 8, 1944
that I last saw him alive on April 7, 1944
and that death occurred on the date and hour stated above.

Immediate cause of death Myocardial Infarction
Arteriosclerotic Hypertension
Acute Nephritis
Due to Arteriosclerotic Hypertension 6 months
Due to Acute Nephritis 2 weeks

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations none

Of autopsy none

Duration 3 months
6 months
2 weeks
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, on farm, in industrial place, in public place?

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

23. Signature J. H. Steeles (M. D. or other)
Address 1701 Jackson Ave Date signed 4/8/44

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

MOTHER FATHER

Lu. at
1701 Jackson

Dr. Keefer.

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 E. M. Plaut

Licensed Embalmer No. 1848

P. O. Address W. E. 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, fact should be so stated above.

Registration District No. **149**

Primary Registration District No. **1002**

1. PLACE OF DEATH:

(a) County **Jackson**
(b) City or town **Ransau City**
(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

3. (a) PRINT FULL NAME

John O. Liles

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

4. Sex **M** 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 **April 26** (Month) (Day) (Year)

8. AGE: Years **68** Months **11** Days _____ (Unless than one day) min.

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

10. Usual occupation _____

11. Industry or 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 _____ (Month) (Day) (Year)
(Burial, cremation, or removal)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (b) _____ (Date received local registrar) (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) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **April** year **1944** hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____; 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 **fulminant cerebral the acute nephritis**
Due to **chronic nephritis of past history**
Other conditions _____ (Include pregnancy within 3 months of death)

Major findings: Of operations _____ Of autopsy _____ **131R**

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? _____

23. Signature **J. H. Keifer** (M. D. or other) _____
While at work? _____ (Specify type of place) (c) Means of injury _____
Address **170 Jackson Ave** Date signed **5-1-44**

SUPPLEMENTARY

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

MOTHER FATHER

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

