

FILED OCT 23 1946
Registration District No. _____

Primary Registration District No. 4234

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

1. PLACE OF DEATH:
(a) County Linn Co
(b) City or town Learton Mo
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
St. Mary's of the Ozarks
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 10 hrs
(Specify whether
In this community WIFE
years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo (b) County Madison
(c) City or town Marguard Mo
(If outside city or town limits, write "RURAL")
(d) Street No. 1
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME James T. Iles
3. (b) If veteran, name war ✓ 3. (c) Social Security No. -

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month Oct day 13
year 1946 hour 8 05 minute PM

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Irene Iles 6. (c) Age of husband or wife if alive 55 years
7. Birth date of deceased Nov 9
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from 10-13-46 19 to 10-13-46 19
that I last saw him alive on 10-13-46 19
and that death occurred on the date and hour stated above.

8. AGE:	Years	Months	Days	If less than one day
	<u>70</u>	<u>11</u>	<u>4</u>	hr. _____ min. _____

Immediate cause of death acute Bistateral Bronchial Pneumonia
Due to _____

9. Birthplace Madison County Mo
(City, town, or county) (State or foreign country)
10. Usual occupation Cashier at Marguard Bank

Due to Cerebral Hemorrhage
Other conditions Hypertension 7/10/13/46
(Include pregnant within 3 months of death) Prostate

11. Industry or business _____
12. Name Wm. Iles
13. Birthplace Calvert City Kentucky
(City, town, or county) (State or foreign country)
14. Maiden name Florence Robbin
15. Birthplace Madison Co Mo
(City, town, or county) (State or foreign country)

Major findings:
Of operations _____
Of autopsy 3A
PHYSICIAN _____
Underline the cause to which death should be charged statistically.

16. (a) Informant W E Iles
(b) Address Marguard Mo

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? _____

17. (a) BURIAL (b) Date thereof 10-15-46
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Stevens Ceme. Marguard Mo
18. (a) Signature of funeral director E. A. Romark
(b) Address Marguard Mo
19. (a) 10-18-46 (b) Madara Jones
(Date received local registrar) (Registrar's signature)

While at work? _____ (Specify type of place)
(e) Means of injury _____
23. Signature R. E. Harland (M. D. or other) _____
Address Learton, Mo Date signed M.D.

RECEIVED

Health Officer No. 4

File Number 1046-2786

10-22-46

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 John H. Selt
Licensed Embalmer No. 4264

P. O. Address Fredericktown, Md.

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.