

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

45099

State File No. ....

12074

FILED JAN 26 1953

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. \_\_\_\_\_

|  |  |   |  |
|--|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).<br>a. STATE <b>Missouri</b><br>b. COUNTY |  |
| b. CITY (If outside corporate limits, write RURAL and give township)<br><b>St. Louis</b> |  | c. CITY (If outside corporate limits, write RURAL and give township)<br><b>St. Louis</b>  |  |
| c. LENGTH OF STAY (in this place)<br><b>19 yrs</b>                                       |  | d. STREET ADDRESS (If rural, give location)<br><b>4406 McPherson Avenue</b>   |  |
| d. FULL NAME OF HOSPITAL OR INSTITUTION<br><b>406 McPherson Avenue</b>                   |  |   |  |

|   |  |   |
|---|--|---|
| 3. NAME OF DECEASED<br>(Type or Print)<br>a. (First) <b>John</b><br>b. (Middle) <b>Chester</b><br>c. (Last) <b>Stiles</b> |  | 4. DATE OF DEATH<br>(Month) (Day) (Year)<br><b>12 - 29 - 1952</b> |
|---|--|---|

|  |                                  |  |  |  |   |  |  |
|--|----------------------------------|--|--|--|---|--|--|
| 5. SEX<br><b>Male</b>  | 6. COLOR OR RACE<br><b>White</b> | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)<br><b>Married</b> | 8. DATE OF BIRTH<br><b>11 - 4 - 1885</b> | 9. AGE (In years last birthday)<br><b>67</b> | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Machine tool maker</b> | 11. BIRTHPLACE (City and State or Foreign Country)<br><b>Springfield, Ohio /</b> | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Machine tool maker</b> |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Schaffner Machine Works</b>      |  |  |   |  |  |

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|---|---|--|
| 13a. FATHER'S NAME<br><b>John H. Stiles</b> | 13b. MOTHER'S MAIDEN NAME<br><b>Mary Ann --</b> | 14. NAME OF HUSBAND OR WIFE<br><b>Cassie R. Stiles</b> |
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|   |   |  |         |
|---|---|--|---------|
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br><b>No</b> | 16. SOCIAL SECURITY NO.<br><b>494-10-9219</b> | 17. INFORMANT'S SIGNATURE OR NAME<br><b>Mrs. Cassie R. Stiles, 4406 McPherson Ave.</b> | ADDRESS |
|---|---|--|---------|

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|---|--|--|--|
| 18. CAUSE OF DEATH<br>Enter only one cause per line for (a), (b), and (c)<br><br>*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death. | MEDICAL CERTIFICATION<br>1. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Coronary occlusion</b><br>ANTECEDENT CAUSES<br>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.<br>DUE TO (b) _____<br>DUE TO (c) _____ |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>immediacy</b> |
| 2. OTHER SIGNIFICANT CONDITIONS<br>Conditions contributing to the death but not related to the disease or condition causing death.  |  |  |  |

|                        |                                  |   |
|------------------------|----------------------------------|---|
| 19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
|------------------------|----------------------------------|---|

|  |  |   |
|--|--|---|
| 21a. ACCIDENT SUICIDE HOMICIDE (Specify) | 21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) |
|--|--|---|

|   |  |   |
|---|--|---|
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | 21f. HOW DID INJURY OCCUR?<br><b>4201</b> |
|---|--|---|

22. I hereby certify that I attended the deceased from **3/19**, 19**49**, to \_\_\_\_\_, 19\_\_\_\_, that I last saw the deceased alive on **May 19**, 19**51**, and that death occurred at **1:50 p.m.**, from the causes and on the date stated above.

|  |                   |                                      |                                     |
|--|-------------------|--------------------------------------|-------------------------------------|
| 23a. SIGNATURE<br><b>Thomas W. Parker M.D.</b> | (Degree or title) | 23b. ADDRESS<br><b>4660 Maryland</b> | 23c. DATE SIGNED<br><b>12/28/52</b> |
|--|-------------------|--------------------------------------|-------------------------------------|

|   |                              |                                    |   |
|---|------------------------------|------------------------------------|---|
| 24a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Removal</b> | 24b. DATE<br><b>12/31/52</b> | 24c. NAME OF CEMETERY OR CREMATORY | 24d. LOCATION (City, town, or county) (State)<br><b>Springfield, Ohio</b> |
|---|------------------------------|------------------------------------|---|

|   |   |  |                                    |
|---|---|--|------------------------------------|
| DATE REC'D BY LOCAL REG.<br><b>DEC 3 1 1952</b> | REGISTRAR'S SIGNATURE<br><b>Carl Smith M.D.</b> | 25. FUNERAL DIRECTOR'S SIGNATURE<br><b>Drehmann-Harral</b> | ADDRESS<br><b>1905 Union Blvd.</b> |
|---|---|--|------------------------------------|

**m 73** (Licensed Embalmer's Statement on Reverse Side)

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

Dr. T. W. Parker  
4660 Maryland

9-12  
1-2

**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 \_\_\_\_\_

Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Student .....  
Student Embalmer

Signed Warren A. Carter

Licensed Embalmer No. 353x

P. O. Address \_\_\_\_\_

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.