

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

19186

State File No. _____

FILED MAY 29 1956

BIRTH NO. _____ REG. DIST. NO. 317 PRIMARY REG. DIST. NO. 500 Registrar's No. 1136

1. PLACE OF DEATH
a. COUNTY St. Louis

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Missouri b. COUNTY _____

b. CITY OR TOWN Rural Wellston c. LENGTH OF STAY (In this place) 2yrs. 3 mos. 3. CITY OR TOWN St. Louis d. Is Residence within limits of a city or incorporated town? Yes No

d. FULL NAME OF HOSPITAL OR INSTITUTION St. Vincent's Hospital e. STREET ADDRESS (If rural, give location) 5637 Reber Place 2139

3. NAME OF DECEASED a. (First) Agnes b. (Middle) _____ c. (Last) Giles 4. DATE OF DEATH (Month) (Day) (Year) May 3, 1956

5. SEX Female 6. COLOR OR RACE White 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Never married 8. DATE OF BIRTH Aug. 15, 1872 9. AGE (In years last birthday) 83 IF UNDER 1 YEAR Months 8 IF UNDER 11 HRS. Hours _____ Min. _____

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None 10b. KIND OF BUSINESS OR INDUSTRY None 11. BIRTHPLACE (City and State or Foreign Country) St. Louis, Missouri 12. CITIZEN OF WHAT COUNTRY? U.S.A.

13a. FATHER'S NAME Thomas Giles 13b. MOTHER'S MAIDEN NAME Winifred Finn 14. NAME OF HUSBAND OR WIFE None

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No 16. SOCIAL SECURITY NO. None 17. INFORMANT'S SIGNATURE OR NAME Nephew - Mr. John F. Giles ADDRESS 6043 Meadowcrest Drive, Dallas, Texas

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)
MEDICAL CERTIFICATION
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Arteriosclerotic Heart Disease INTERVAL BETWEEN ONSET AND DEATH 3 years

ANTECEDENT CAUSES DUE TO (b) Generalized Arteriosclerosis Years _____

DUE TO (c) _____
II. OTHER SIGNIFICANT CONDITIONS Chronic Brain Syndrome Associated with Senile Brain Disease, psychotic Reaction Years _____

19a. DATE OF OPERATION _____ 19b. MAJOR FINDINGS OF OPERATION _____ 20. AUTOPSY? YES NO

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) 4200

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.) _____ 21e. INJURY OCCURRED WHILE AT WORK NOT WHILE AT WORK 21f. HOW DID INJURY OCCUR? _____

22. I hereby certify that I attended the deceased from 2-2- 1954, to 5-3- 1956, that I last saw the deceased alive on 5-3- 1956, and that death occurred at 3:15 Pm., from the causes and on the date stated above.

23a. SIGNATURE W.B. Lytton M.D. (Degree or title) 23b. ADDRESS 7301 St. Charles Rock Rd. 23c. DATE SIGNED 5/3/56

24a. BURIAL, CREMATION, REMOVAL (Specify) Removal 24b. DATE 5-5-1956 24c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery 24d. LOCATION (City, town, or county) (State) St. Louis, Mo.

DATE REC'D BY LOCAL REG. 5-4-56 REGISTRAR'S SIGNATURE Herbert R. Lombard 25. FUNERAL DIRECTOR'S SIGNATURE Cullinane Bros. ADDRESS 3320 N. Kingshighway

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

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.....
Signature of Student Embalmer

Signed.....
Fred Frick

Licensed Embalmer No. *318*

P. O. Address *St. Louis*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (F to comply with the above constitutes grounds for revocation of license).
If embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.