

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-023435

FILED JUL 13 1959

Registration District No. _____ Primary Registration District No. _____

STATE FILE NUMBER
Registration No. 5992

300
1-57

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Illinois</u> b. COUNTY <u>Crawford</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. Louis, Missouri.</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>Palestine</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Christian Hospital</u>		Length of stay in lb. <u>3 days</u>	d. STREET ADDRESS (If outside, give location) <u>300 West Market St.,</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>Percy</u> Middle <u>E.</u> Last <u>Stiles</u>			4. DATE OF DEATH Month <u>June</u> Day <u>24</u> Year <u>1959</u>		
---	--	--	--	--	--

5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>January 4, 1878</u>	9. AGE (In years last birthday) <u>81</u>	IF UNDER 1 YEAR Months _____ Days _____ Hours _____ Min. _____	IF UNDER 24 HRS Hours _____ Min. _____
-----------------------	----------------------------------	--	--	--	---	---

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Minister</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Christian Church</u>	11. BIRTHPLACE (City and state or country) <u>Hutsonville, Illinois.</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
--	--	---	---

13a. FATHER'S NAME <u>Norton Stiles</u>	13b. MOTHER'S MAIDEN NAME <u>Elizabeth Bradbury</u>	14. NAME OF HUSBAND OR WIFE <u>Birdie Stiles</u>
--	--	---

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <u>No</u>	16. SOCIAL SECURITY NO. <u>Nil</u>	17. INFORMANT <u>Birdie Stiles, 300 West Market, Palestine, Ill.</u>	Address
--	---------------------------------------	---	---------

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive Heart Disease</u> DUE TO (b) <u>Arteriosclerotic Heart Disease</u> DUE TO (c) <u>General Arteriosclerosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>420.0</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>

20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)
---	--

20c. TIME OF INJURY Hour _____ a.m. _____ p.m.	20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION COUNTY _____ STATE _____
---	---	--	--

21. I attended the deceased from Death occurred at <u>June 19, 1959</u> to <u>June 24, 1959</u> and last saw ^{her} alive on <u>June 24, 1959</u> on the date stated above; and to the best of my knowledge, from the causes stated.
--

22a. SIGNATURE (Degree or title) <u>Julius Olson, M.D.</u>	22b. ADDRESS <u>607 N. Grand</u>	22c. DATE SIGNED <u>6/23/59</u>
---	-------------------------------------	------------------------------------

23a. BURIAL CREMATION, REMOVAL (Specify) <u>Removal</u>	23b. DATE <u>6-24-59</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Palestine Cemetery</u>	23d. LOCATION (City, town, or county) <u>Palestine, Illinois.</u>
--	-----------------------------	---	--

24. FUNERAL DIRECTOR <u>Albert H. Hoppe, 4700 Washington Blvd.</u>	25. DATE RECD. BY LOCAL REG. <u>JUN 24 59</u>	26. REGISTRAR'S SIGNATURE <u>W. Earl Smith, M.D.</u>
---	--	---

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

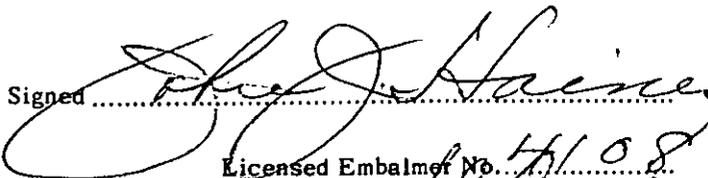
MEDICAL CERTIFICATION

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

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 
Licensed Embalmer No. 4108
P. O. Address St. Louis

**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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.**