

**FEDERAL BUREAU OF INVESTIGATION - U.S. DEPARTMENT OF JUSTICE**  
**FEDERAL DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH**

FILED VS NOV 6 1959

59-036705

STATE FILE NUMBER

Registration District No. 159 Primary Registration District No. 4249 Registrar's No. 75

INDEXED

1. PLACE OF DEATH a. COUNTY <b>Jefferson</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Mo.</b> b. COUNTY				
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Hillsboro</b>		Length of stay in 1b <b>3 Weeks</b>		c. CITY OR TOWN <b>St. Louis</b>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		
c. FULL NAME OF (If NOT in hospital, give location) Home HOSPITAL OR INSTITUTION <b>Castle Acres Nursing</b>			Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <b>4239 Norfolk Ave.</b>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>VERNE</b> Middle <b>F.</b> Last <b>WILES</b>				4. DATE OF DEATH Month <b>Oct.</b> Day <b>31</b> Year <b>1959</b>				
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <b>7-17-1892</b>	9. AGE (last birthday) <b>67</b>	IF UNDER 1 YEAR Months	IF UNDER 24 HR Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Street Car Operator (Retired)</b>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) <b>Belfast, Iowa</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>	
13a. FATHER'S NAME <b>Robert L. Wiles</b>			13b. MOTHER'S MAIDEN NAME <b>Sophia Woodard</b>			14. NAME OF HUSBAND OR WIFE <b>Hazel Wiles</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>yes world war I</b>			16. SOCIAL SECURITY NO. <b>493-10-8989</b>		17. INFORMANT Address <b>Hazel Wiles 4239 Norfolk Ave.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral arterio-sclerosis</b>							INTERVAL BETWEEN ONSET AND DEATH <b>yes</b>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>Cerebral thrombosis</b>							<b>2 weeks</b>	
DUE TO (c)								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)					PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" 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.) <b>no.</b>				
20c. TIME OF INJURY Hour a.m. p.m.		Month, Day, Year						
20d. INJURY OCCURRED WHILE AT WORK <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 <b>Oct 17, 59</b> to <b>Oct 31, 59</b> and last saw him alive on <b>Oct 30, 59</b> Death occurred at <b>11:45 P.</b> on the date stated above, and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE (Degree or title) <b>Mar V. Holmstrom M.D.</b>				22b. ADDRESS <b>Felers mo</b>			22c. DATE SIGNED <b>Nov 2, 59</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		23b. DATE <b>Nov. 4, 1959</b>	23c. NAME OF CEMETERY OR CREMATORY <b>National Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Jefferson Barracks, Mo.</b>			
24. FUNERAL DIRECTOR ADDRESS <b>Kriegshauser 4228 S.Kingshighway</b>				25. DATE RECD. BY LOCAL REG. <b>11-2-59</b>		26. REGISTRAR'S SIGNATURE <b>Oliver B. ...</b>		

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

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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 Geo. H. Kueghansen, Jr.

Licensed Embalmer No. 4988

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