

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATHState File No. **6670**

FILED MAR 4 1954

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. **1533**

1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri. b. COUNTY Laclede					
b. CITY (If outside corporate limits, write RURAL and give township) TOWN ST. LOUIS, MISSOURI		c. LENGTH OF STAY (in this place)		c. CITY OR TOWN Lebanon		d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>			
d. FULL NAME OF HOSPITAL OR INSTITUTION BARNES HOSPITAL				e. STREET ADDRESS (If rural, give location) 275 No, Monroe					
3. NAME OF DECEASED (Type or Print) a. (First) EVA			b. (Middle) MAE		c. (Last) PILES		4. DATE OF DEATH (Month) (Day) (Year) February 16, 1954		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH Aug. 1, 1900.		9. AGE (In years last birthday) 53	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	IF UNDER 2 HRS. Hours	IF UNDER 15 MIN. Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Saleslady			10b. KIND OF BUSINESS OR INDUSTRY Dry Goods		11. BIRTHPLACE (City and State or Foreign Country) Camden County, Mo. 0			12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13a. FATHER'S NAME W. M. Caviness			13b. MOTHER'S MAIDEN NAME Maggie Parish			14. NAME OF HUSBAND OR WIFE Walter Piles			
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. 547-14-8863		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Walter Piles, Lebanon, Missouri.				
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.				MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral edema				INTERVAL BETWEEN ONSET AND DEATH 2 wks.	
				ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Brain tumor (type undetermined)				2-3 yrs.	
				DUE TO (c)					
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.									
19a. DATE OF OPERATION 2-14-54		19b. MAJOR FINDINGS OF OPERATION Brain Tumor, Left temporal region					20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input 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? 237X					
22. I hereby certify that I attended the deceased from 2-13- , 19 54 , to 2-16- , 19 54 , that I last saw the deceased alive on 2-16- , 19 54 , and that death occurred at 1:50A m. , from the causes and on the date stated above.									
23a. SIGNATURE <i>C. J. Vermillion, M.D.</i>				23b. ADDRESS M. D. BARNES HOSPITAL		23c. DATE SIGNED 2-16-54			
24a. BURIAL, CREMATION, REMOVAL (Specify) Removal		24b. DATE 2-16-54	24c. NAME OF CEMETERY OR CREMATORY Lebanon		24d. LOCATION (City, town, or county) (State) Lebanon, Missouri.				
DATE REC'D BY LOCAL REG. FEB 16 1954		REGISTRAR'S SIGNATURE <i>Carl Smith M.D.</i>			25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Albert H. Hoppe 4700 Washington.				

(Licensed Embalmer's Statement on Reverse Side)

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

MAY 27 1958

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 *G. W. Wilkinson*.....

Licensed Embalmer No. *35*.....

P. O. Address *St. Louis*.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (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.