

FILED APR 26 1954

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **14259**
Registrar's No. **3168**

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Mo. b. COUNTY St. Louis	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis		c. CITY OR TOWN Webster Groves d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>	
c. LENGTH OF STAY (In this place) 9 Days		e. STREET ADDRESS (If rural, give location) 525 Clark Ave.	
d. FULL NAME OF HOSPITAL OR INSTITUTION: Deaconess Hospital			

3. NAME OF DECEASED (Type or Print)	a. (First) VERNON	b. (Middle) BAILEY	c. (Last) WILFLEY	4. DATE OF DEATH (Month) (Day) (Year) 4-6-1954
-------------------------------------	--------------------------	---------------------------	--------------------------	---

5. SEX M	6. COLOR OR RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH 12-11-1897	9. AGE (In years last birthday) 56	10 UNDER: YEAR Months Days	11 UNDER: HRS. Hours Min.
-----------------	---------------------------	---	------------------------------------	---	----------------------------	---------------------------

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Elec. Engineer	10b. KIND OF BUSINESS OR INDUSTRY Westinghouse Co.	11. BIRTHPLACE (City and State or Foreign Country) Clarinda Iowa	12. CITIZEN OF WHAT COUNTRY? USA
---	---	---	---

13a. FATHER'S NAME James R Wilfley	13b. MOTHER'S MAIDEN NAME Isabella Bailey	14. NAME OF HUSBAND OR WIFE Blanche Wilfley
---	--	--

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes WW # 1	16. SOCIAL SECURITY NO. 541-01-5511	17. INFORMANT'S SIGNATURE OR NAME ADDRESS Mrs. V.B. Wilfley 525 Clark Ave.
--	--	---

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, asthma, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Coronary Infarction		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ 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	19b. MAJOR FINDINGS OF OPERATION	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) 4201
--	--	---

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

22. I hereby certify that I attended the deceased from **Mar. 28 1954** to **Apr. 6 1954**, that I last saw the deceased alive on **Apr. 6 1954**, and that death occurred at **8:30 p.m.**, from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) J. E. Williamson M.D.	23b. ADDRESS 6336 Clayton Road	23c. DATE SIGNED 4/7/54
---	---------------------------------------	--------------------------------

24a. BURIAL, CREMATION, REMOVAL (Specify) Cremation	24b. DATE 4-8-1954	24c. NAME OF CEMETERY OR CREMATORY Valhalla Crematory	24d. LOCATION (City, town, or county) (State) St. Louis Mo.
--	---------------------------	--	--

DATE REC'D BY LOCAL REG. APR 8 1954	REGISTRAR'S SIGNATURE J. Earl Smith, M.D.	FUNERAL DIRECTOR'S SIGNATURE ADDRESS Parker Aldrich 7 Home Webster Groves Mo.
--	--	--

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 *Donald O. Yahn*.....

Licensed Embalmer No. *391*.....

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.