

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-006236

STATE FILE NUMBER

FEB 24 1959

Registration District No. 174 Primary Registration District No. 3035 Registrar's No. 11

1. PLACE OF DEATH a. COUNTY <u>Lafayette</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Lafayette</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Lexington</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>Higginsville</u> 540 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>Memorial Hospital</u>		Length of stay in 1b <u>5 days.</u>	d. STREET ADDRESS <u>1004 Walnut</u> (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Middle Last <u>Charles James Tilley</u>			4. DATE OF DEATH Month Day Year <u>February 2 1959</u>		
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan. 4, 1895</u>		9. AGE (In years last birthday) <u>64</u>

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>mail carrier</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Gov.</u>	11. BIRTHPLACE (City and state or country) <u>Sweet Springs, Missouri</u>	12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>
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13a. FATHER'S NAME <u>James H Tilley</u>	13b. MOTHER'S MAIDEN NAME <u>Laura Wickey</u>	14. NAME OF HUSBAND OR WIFE <u>Emma Pestorff Tilley</u>
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <u>yes World War I July 4, 1918 Home</u>	16. SOCIAL SECURITY NO. <u>332x</u>	17. INFORMANT <u>Mrs. Emma Tilley</u>	Address <u>Higginsville, Mo</u>
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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>Cerebral Thrombosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>Generalized arteriosclerosis</u>	
	DUE TO (c) <u>Chronic glomerulonephritis</u>	

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Chronic glomerulonephritis</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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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.)
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20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.	20d. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20e. CITY, TOWN, OR LOCATION	COUNTY	STATE
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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
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21. I attended the deceased from Death occurred at <u>Jan. 25 1959 3:30 PM</u> and last saw her/him alive on <u>Feb. 2 - 1959</u> on the date stated above; and to the best of my knowledge, from the causes stated.
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22a. SIGNATURE <u>H. Skoppenboud, MD</u> (Degree or title)	22b. ADDRESS <u>Higginsville Mo</u>	22c. DATE SIGNED <u>Feb 3 - 59</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>Feb 4, 1959</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Higginsville City Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>Higginsville, Missouri</u>
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24. FUNERAL DIRECTOR <u>Roy F. Wiegert</u>	ADDRESS <u>Higginsville Mo</u>	25. DATE RECD. BY LOCAL REG. <u>6 Feb 1959</u>	26. REGISTRAR'S SIGNATURE <u>Thomas E. Eastman</u>
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(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

APR 11 1963

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 *Prof. H. W. Wiegman*

Licensed Embalmer No. *2983*

P. O. Address *Higginville*

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.