

**IRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH**

**-60-004158**

**FILED VS FEB 10 1960**

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_ Registrar's No. **2 1212** STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>ST. LOUIS, MISSOURI</b>		Length of stay in lb <b>15 days</b>	c. CITY OR TOWN <b>Woodriver</b>
c. FULL NAME OF HOSPITAL OR INSTITUTION <b>BARNES HOSPITAL</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>229 Pennig Street.,</b>

3. NAME OF DECEASED (Type or print)	First	Middle	Last	4. DATE OF DEATH	Month	Day	Year
	<b>WILLIAM</b>	<b>GEORGE</b>	<b>TILEY</b>	<b>FEBRUARY</b>	<b>1</b>	<b>1960</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>2/22/1916</b>	9. AGE (last birthday) <b>43</b>	IF UNDER 1 YEAR Months	IF UNDER 24 HR Days	Hours	Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Chief of Police</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>Police Department</b>	11. BIRTHPLACE (City and state or country) <b>O'Fallon, Illinois.</b>	12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>
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13a. FATHER'S NAME <b>John T. Tiley</b>	13b. MOTHER'S MAIDEN NAME <b>Mary Eckert</b>	14. NAME OF HUSBAND OR WIFE <b>Margaret Tiley</b>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>Yes W.W. 11</b>	16. SOCIAL SECURITY NO. <b>Unknown</b>	17. INFORMANT <b>Margaret Tiley, 229 Pennig Street.,</b>
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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:		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	<b>THROMBOSIS OF ABDOMINAL AORTA</b>	<b>6 HOURS</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <b>ARTERIOSCLEROSIS</b>	<b>SEVERAL YRS.</b>
	DUE TO (c) <b>450.0</b>	

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (e)	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
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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.)
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20c. TIME OF INJURY Hour _____ a.m. _____ p.m. _____	Month, Day, Year
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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 **JAN 16, 1960** to **FEB. 1, 1960** and last saw her/him alive on **FEB. 1, 1960**  
Death occurred at **7:55 A.M.** on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <i>E. O. Vermillion, M.D.</i>	(Degree or title) <b>M. D.</b>	22b. ADDRESS <b>BARNES HOSPITAL</b>	22c. DATE SIGNED <b>2/1/60</b>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	23b. DATE <b>2/1/60</b>	23c. NAME OF CEMETERY OR CREMATORY <b>O'Fallon Cemetery</b>	23d. LOCATION (City, town, or county) <b>O'Fallon, Illinois.</b>
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24. FUNERAL DIRECTOR <b>Albert H. Hoppe Inc., 4700 Washington Blvd.,</b>	ADDRESS	25. DATE RECD. BY LOCAL REG. <b>FEB 2 1960</b>	26. REGISTRAR'S SIGNATURE <i>Earl Smith, M.D.</i>
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DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by \_\_\_\_\_ or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_ working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed Stanley H. Rifon

Licensed Embalmer No. 419

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.