DEPARTMENT OF PUBLIC HEALTH AND WELFARE – MISSOURI DIVISION OF HEALTH
(PHYSICIAN OR CORONER)

CERTIFICATE OF DEATH

124

STATE FILE NUMBER
69-012941

FILED APR 8 1969

Registration District No. 5316 Primary Registration District No. 6075 Registrar's No. 118

VS 300
Rev. 1/68

DO NOT WRITE ON THIS STUB

9.	0
10a.	98
10b.	
11.	0
12.	2
13.	4409
14.	4
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19. CREDITS	
20.	1-0

4. 0940
5. 02

DECEASED

1. DECEASED—NAME: Wendell Guy Haile
2. SEX: Male
3. DATE OF DEATH (MONTH, DAY, YEAR): April 4, 1969
4. RACE (WHITE, NEGRO, AMERICAN INDIAN, ETC.) (SPECIFY): White
5a. AGE—LAST BIRTHDAY (YEARS): 98
5b. UNDER 1 YEAR: MOS. / DAYS
5c. UNDER 1 DAY: HOURS / MIN.
6. DATE OF BIRTH (MONTH, DAY, YEAR): March 14, 1871
7a. COUNTY OF DEATH: ST. FRANCOIS
7b. CITY, TOWN, OR LOCATION OF DEATH: St. Francois Twp. Farmington, Mo. rural
INSIDE CITY LIMITS (SPECIFY YES OR NO): No
7c. HOSPITAL OR OTHER INSTITUTION—NAME (IF NOT IN EITHER, GIVE STREET AND NUMBER): Mineral Area Osteopathic Hospital
8. STATE OF BIRTH (IF NOT IN U.S.A., NAME COUNTRY): Missouri
CITIZEN OF WHAT COUNTRY: USA.
10. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (SPECIFY): Widowed
11. SURVIVING SPOUSE (IF WIFE, GIVE MAIDEN NAME):
12. SOCIAL SECURITY NUMBER:
13a. USUAL OCCUPATION (GIVE KIND OF WORK DONE DURING MOST OF WORKING LIFE, EVEN IF RETIRED): Retired Farmer
13b. KIND OF BUSINESS OR INDUSTRY: Owned Farm

USUAL RESIDENCE WHERE DECEASED LIVED. IF DEATH OCCURRED IN INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION.

6. 0940

14a. RESIDENCE—STATE: Missouri
14b. COUNTY: St. Fran.
14c. CITY, TOWN, OR LOCATION: Desloge, Mo.
14d. INSIDE CITY LIMITS (SPECIFY YES OR NO): Yes
14e. STREET AND NUMBER: 202 Vadervoort

PARENTS

15. FATHER—NAME: Samuel Guy Haile
16. MOTHER—MAIDEN NAME: Virginia Hutchings

17a. INFORMANT—NAME: Mrs. Grace Merritt
17b. MAILING ADDRESS (STREET OR R.F.D. NO., CITY OR TOWN, STATE, ZIP): 202 Vandervoort St., Desloge, Mo. 63601

CAUSE

PART I. DEATH WAS CAUSED BY: (ENTER ONLY ONE CAUSE PER LINE FOR (a), (b), AND (c))

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
18 IMMEDIATE CAUSE (a)	Myocardial Failure	Sudden
DUE TO, OR AS A CONSEQUENCE OF (b)	Hypostatic Pneumonia	1 day
DUE TO, OR AS A CONSEQUENCE OF (c)	Arteriosclerosis	Sudden

CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST

PART II. OTHER SIGNIFICANT CONDITIONS: CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO CAUSE GIVEN IN PART I (a)

19a. AUTOPSY (YES OR NO): No
19b. IF YES WERE FINDINGS CONSIDERED IN DETERMINING CAUSE OF DEATH:

20a. ACCIDENT, SUICIDE, HOMICIDE, OR UNDETERMINED (SPECIFY):
20b. DATE OF INJURY (MONTH, DAY, YEAR):
20c. HOUR: M.
20d. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN PART I OR PART II, ITEM 18):
20e. INJURY AT WORK (SPECIFY YES OR NO):
20f. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BLDG., ETC.) (SPECIFY):
20g. LOCATION (STREET OR R.F.D. NO., CITY OR TOWN, STATE):

CERTIFIER

21a. CERTIFICATION—PHYSICIAN: I ATTENDED THE DECEASED FROM (MONTH, DAY, YEAR) March 13, 1969 TO (MONTH, DAY, YEAR) April 1, 1969
21c. AND LAST SAW HIM/HER ALIVE ON (MONTH, DAY, YEAR): Mar. 29, 1969
21d. I DID/DID NOT VIEW THE BODY AFTER DEATH: Did not
21e. DEATH OCCURRED (HOUR): 12:30pm
AT THE PLACE, ON THE DATE, AND, TO THE BEST OF MY KNOWLEDGE, DUE TO THE CAUSE(S) STATED.

22a. CERTIFICATION—MEDICAL EXAMINER OR CORONER: ON THE BASIS OF THE EXAMINATION OF THE BODY AND/OR THE INVESTIGATION, IN MY OPINION, DEATH OCCURRED ON THE DATE AND DUE TO THE CAUSE(S) STATED.
HOUR OF DEATH: M.
22b. THE DECEDENT WAS PRONOUNCED DEAD (MONTH, DAY, YEAR, HOUR): M.

23a. CERTIFIER—NAME (TYPE OR PRINT): L. M. Stanfield, D.O.
23b. SIGNATURE: L. M. Stanfield D.O.
DEGREE OR TITLE:
23c. DATE SIGNED (MONTH, DAY, YEAR): 4-4-1969
23d. MAILING ADDRESS—CERTIFIER (STREET OR R.F.D. NO., CITY OR TOWN, STATE): 4 E. Harrison St., Farmington, Mo. 63640

BURIAL

24a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial
24b. CEMETERY OR CREMATORY—NAME: Herod Cemetery
24c. LOCATION (CITY OR TOWN, STATE): Desloge, Mo.
24d. DATE (MONTH, DAY, YEAR): April 4, 1969
25a. FUNERAL HOME—NAME AND ADDRESS (STREET OR R.F.D. NO., CITY OR TOWN, STATE, ZIP): C. Z. Boyer & Son, Inc., 201 E. Chestnut, Desloge, Mo.
25b. FUNERAL DIRECTOR—SIGNATURE: B. I. Boyer
26a. REGISTRAR—SIGNATURE: Esther Mathews
26b. DATE RECEIVED BY LOCAL REGISTRAR: April 4, 1969

Type or print in PERMANENT BLACK INK. See handbook for instructions.

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 B. T. Boyer

Licensed Embalmer No. 3660

P. O. Address Ledoux 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.