

FILED JAN 10 1955

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATHState File No. **41543**

BIRTH NO. _____		REG. DIST. NO. <u>167</u>		PRIMARY REG. DIST. NO. <u>5646</u>		Registrar's No. <u>40</u>	
1. PLACE OF DEATH a. COUNTY <u>JOHNSON</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>MISSOURI</u> b. COUNTY <u>JOHNSON</u>			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>RURAL Johnson</u>		c. LENGTH OF STAY (in this place) <u>10</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>RURAL</u>		<u>0510</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>ROUTE #</u>				d. STREET ADDRESS (If rural, give location) <u>0</u>			
3. NAME OF DECEASED (Type or Print) a. (First) <u>CORNELIA</u>			b. (Middle) <u>ANN PATTERSON</u>		c. (Last) <u>HAILE</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>DEC. 23, 1954</u>
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>WIDOWED</u>		8. DATE OF BIRTH <u>MAR. 14, 1872</u>	
9. AGE (In years last birthday) <u>82</u>		10. KIND OF BUSINESS OR INDUSTRY <u>HOME.</u>		11. BIRTHPLACE (City and State or Foreign Country) <u>JOHNSON COUNTY, MO</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>HOME.</u>		11. BIRTHPLACE (City and State or Foreign Country) <u>JOHNSON COUNTY, MO</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13a. FATHER'S NAME <u>THOMAS A. PATTERSON</u>			13b. MOTHER'S MAIDEN NAME <u>MINERVA E. POINDEXTER</u>		14. NAME OF HUSBAND OR WIFE <u>THOMAS J. HAILE - DECEASED</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>MRS. LOFTON GOTT, KINGSVILLE, MO.</u>			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) <b>MEDICAL CERTIFICATION</b>							
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Chronic Myocarditis</u>		INTERVAL BETWEEN ONSET AND DEATH					
*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.		ANTECEDENT CAUSES					
DUE TO (b) _____		DUE TO (c) _____					
II. OTHER SIGNIFICANT CONDITIONS* <u>Sen Arteriosclerosis</u>		Conditions contributing to the death but not related to the disease or condition causing death.					
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION <u>4221</u>				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" 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) (Min.)		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 <u>Mar</u> , 19 <u>50</u> , to <u>Dec</u> , 19 <u>54</u> , that I last saw the deceased alive on <u>Dec 16, 1954</u> , and that death occurred at <u>9 A. m.</u> , from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) <u>OKelly Rawlin M.D.</u>				23b. ADDRESS <u>Holden Mo</u>		23c. DATE SIGNED <u>12/23/54</u>	
24a. BURIAL, CREMATION REMOVAL (Specify) <u>BURIAL</u>		24b. DATE <u>12-24-1954</u>		24c. NAME OF CEMETERY OR CREMATORY <u>ELM SPRINGS CEMETERY</u>		24d. LOCATION (City, town, or county) (State) <u>ELM - JOHNSON CO. MO.</u>	
DATE REC'D BY LOCAL REG. <u>12-28-54</u>		REGISTRAR'S SIGNATURE <u>Mrs H D Redford</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>E B Cost</u>		ADDRESS <u>Holden, Mo.</u>	

(Licensed Embalmer's Statement on Reverse Side)

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

No. 300  
10-48

510

RECEIVED  
JAN 7 1955  
RECEIVED  
JOHNSON COUNTY HEALTH DEPT.

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 .....  
Student Embalmer

Signed *E. B. Cant*

Licensed Embalmer No. 4059

P. O. Address Holden, 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 this body is not embalmed, fact should be so stated above.