

URR DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-039099

XC-16211188 REG. NO. 151 FILED VS DEC 11 1959  
 Registration District No. 45 Primary Registration District No. 2007 Registrar's No. 571

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <b>BUTLER</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MISSOURI</b> b. COUNTY <b>NEW MADRID</b>					
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>POPLAR BLUFF</b>		Length of stay in 1b <b>29 DAYS</b>		c. CITY OR TOWN <b>NEW MADRID</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>VETERANS ADM. HOSPITAL</b>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <b>435 LINE STREET</b>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Middle Last <b>WILLIAM SANFORD HALE</b>				4. DATE OF DEATH Month Day Year <b>NOVEMBER 25, 1959</b>					
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <b>5-2-93</b>	9. AGE (last birthday) <b>66</b>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>TAXI DRIVER</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>TRANSPORTATION</b>		11. BIRTHPLACE (City and state or country) <b>UNION CITY, TENNESSEE</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>		
13a. FATHER'S NAME <b>JOHN HALE</b>			13b. MOTHER'S MAIDEN NAME <b>MARY STANLEY</b>			14. NAME OF HUSBAND OR WIFE <b>NOT APPLICABLE</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>YES WWI</b>			16. SOCIAL SECURITY NO. <b>495165168</b>		17. INFORMANT Address <b>VA HOSPITAL, POPLAR BLUFF, MO.</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>1. MYOCARDIAL FAILURE.</b>							INTERVAL BETWEEN ONSET AND DEATH <b>1 Day</b>		
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. <del>due to 2. ATELECTASIS, RIGHT, LOWER LOBE.</del>							<b>1 Day</b>		
<del>due to 3. PNEUMONIA, BRONCHIAL.</del>							<b>1 Day</b>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>1. CHOLELITHIASIS. 2. CHRONIC CHOLECYSTITIS. 3. HEPATIC CALCINOSIS.</b>					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				
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" 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.)					
20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.			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		
21. I attended the deceased from <b>Oct. 27, 1959</b> to <b>Nov. 25, 1959</b> and last saw her/him alive on <b>Nov. 25, 1959</b> Death occurred at <b>1250AM</b> on the date stated above, and to the best of my knowledge, from the causes stated.				22a. OCCUPATION (Degree or title) <b>C. W. GASKINS, M.D., Chief, Surgical Svc.</b>				22b. ADDRESS <b>VA HOSPITAL, POPLAR BLUFF, MO.</b>	
22c. DATE SIGNED <b>11/30/59</b>				23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>					
23b. DATE <b>11-27-59</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Evergreen</b>			23d. LOCATION (City, town, or county) (State) <b>New Madrid, Mo.</b>				
24. FUNERAL DIRECTOR <b>Richards Und't Co. New Madrid,</b>			25. DATE RECD. BY LOCAL REG. <b>12/2/59</b>		26. REGISTRAR'S SIGNATURE <i>[Signature]</i>				

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 me  
or by \_\_\_\_\_ Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

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

Signed <sup>X</sup> or *L. S. Hedgcock*

Licensed Embalmer No. 3803  
P. O. Address New Mad

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.