

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

63-035954

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. 141 Primary Registration District No. 3025 Registrar's No. 135

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

**FILED SEP 16 1963**

VS 300  
Rev. 4/59

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

USE BLACK INK OR TYPEWRITER RIBBON

1. PLACE OF DEATH a. COUNTY <u>Howell</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Howell</u>		
b. CITY (If outside corporate limits, give TOWNSHIP only) <u>West Plains</u>		Length of stay in 1b <u>6 hrs</u>	c. CITY OR TOWN <u>Pomona</u>		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>West Plains Memorial</u>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (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>Sylvester wailes</u>			4. DATE OF DEATH Month Day Year <u>September 13, 1963</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>7/16/1884</u>	9. AGE (last birthday) <u>79</u>	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>General Farming</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farming</u>	11. BIRTHPLACE (City and state or country) <u>Plano, Iowa</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>
13a. FATHER'S NAME <u>George Naylor Wailes</u>		13b. MOTHER'S MAIDEN NAME <u>Elizabeth Ellen Mitchell</u>		14. NAME OF HUSBAND OR WIFE <u>Lottie Suchow Wailes</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of serv)		16. SOCIAL SECURITY NO.	17. INFORMANT Address <u>Mrs. Lottie Wailes, Pomona, Mo.</u>		
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>Cardiac decompensation</u> DUE TO (b) <u>Myocardial infarction</u> DUE TO (c) <u>A.S.H.D.</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.					INTERVAL BETWEEN ONSET AND DEATH <u>12 hr,</u> <u>12 hr,</u> <u>?</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)				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 a.m. p.m. Month, Day, Year					
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 _____ to _____ and last saw <sup>her</sup> him alive on <u>9-13-63</u> Death occurred at <u>6:50 AM</u> m on the date stated above, and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <u>John E. Wilson, M.D.</u>		(Degree or title)		22b. ADDRESS <u>West Plains, Mo.</u>	22c. DATE SIGNED <u>9-13-63</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>9/16/63</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Philadelphia Cemetery near Centerville, Iowa</u>		23d. LOCATION (City, town, or county) <u>(State)</u>
24. FUNERAL DIRECTOR <u>Carter Funeral Home, West Plains, Mo.</u>		ADDRESS	25. DATE RECD. BY LOCAL REG. <u>9-14-63</u>	26. REGISTRAR'S SIGNATURE <u>Beatrice Cook</u>	

**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 Herman R. Sheppard

Licensed Embalmer No. 965 R45

P. O. Address Shaver 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.