DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED MAR 11 1940

MISSOURI STATE BOARD OF HEALTH

# STANDARD CERTIFICATE OF DEATH

State File No. 5677

Registration District No. 399 — Primary Registration District No. 1002 — Registrar's No. 902

**1. PLACE OF DEATH:**

(a) County Jackson

(b) City or town Kansas City (If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: K.C.Gen.HospitalNo.1 (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 43 days (Specify whether

In this community 15 years (years, months or days)

**2. USUAL RESIDENCE OF DECEASED:**

(a) State Missouri (b) County Jackson

(c) City or town Kansas City (If outside city or town limits, write "RURAL")

(d) Street No. 4214 E. 53rd St.Terrace (If rural, give location)

(e) If foreign born, how long in U. S. A.? ..... years.

3. (a) PRINT FULL NAME 5 20 LIVA RAINES

3. (b) If veteran, name war No

3. (c) Social Security No. No

4. Sex Female

5. Color or race White

6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Commodore Raines

6. (c) Age of husband or wife if alive 54 years

7. Birth date of deceased July 9, 1901 (Month) (Day) (Year)

8. AGE: Years 48 Months 7 Days 16 If less than one day ..... hr. ..... min.

9. Birthplace unknown (City, town, or county) Missouri (State or foreign country)

10. Usual occupation Housewife

11. Industry or business No

FATHER
12. Name Mares Shelton
13. Birthplace unknown (City, town, or county) Missouri (State or foreign country)

MOTHER
14. Maiden name Eva unknown
15. Birthplace unknown (City, town, or county) Missouri (State or foreign country)

16. (a) Informant's own signature Commodore Raines

(b) Address 4214 East 53rd street, K.C.Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. 27,1940 (Month) (Day) (Year)

(c) Place: burial or cremation Pisgah Cemetery,Excelsior Springs, Mo.

18. (a) Signature of funeral director Mrs.C.L. Forster

(b) Address 918 Brooklyn ave. Kansas City Mo.

19. (a) 2-28-40 (Date received local registrar) (b) M. M. Crowe (Registrar's signature)

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Month Feb. day 25th year 1940 hour 5 minute 15 P. M.

21. I hereby certify that I attended the deceased from 1-9-40, 19..., to 2-25-40, 19...; that I last saw her alive on 2-25-40, 19...; and that death occurred on the date and hour stated above.

Immediate cause of death Annual carcinoma of rectum; Fecal fistula; generalized peritonitis — Duration 1935

Due to

Due to

Other conditions Metastatic carcinoma of pre-vertebral lymph nodes and liver (Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy See above

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify)

(b) Date of occurrence

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? (Specify type of place)

While at work? (e) Means of injury

23. Signature R. F. De Maria M.D. (M.D. or other)
Supt. K.C.Gen.Hospital, K.C.Mo. 2-26-40
Address Date signed

(Licensed Embalmer's Statement on Reverse Side)

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

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

Rev. 5-17-39 1 X19511

## 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 me

....., Registered Apprentice No.....,

working under my personal supervision.

Signed Denzil C. Browning

Licensed Embalmer No. 2724

P. O. Address K. C. 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, above space should be left blank.**

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Registration District No. 399 Primary Registration District No. 1002 Registrar's No. 902

**1. PLACE OF DEATH:**

(a) County: Jackson

(b) City or town: Kansas City

(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:

(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution (Specify whether years, months or days)

In this community

3. (a) PRINT FULL NAME: Lira Raines

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex: F

5. Color or race: W

6. (a) Single, widowed, married, divorced: M

6. (b) Name of husband or wife

6. (c) Age of husband, or wife, if alive

7. Birth date of deceased: July (Month) 9 (Day) 1881 (Year)

8. AGE: Years 48 Months 7 Days 16 If less than one day h. min.

9. Birthplace (City, town, or county) (State or foreign country)

10. Usual occupation

11. Industry or business

FATHER 12. Name

13. Birthplace (City, town, or county) (State or foreign country)

MOTHER 14. Maiden name

15. Birthplace (City, town, or county) (State or foreign country)

16. (a) Informant

(b) Address

17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)

(c) Place: burial or cremation

18. (a) Signature of funeral director

(b) Address

19. (a) 2/27/40 (Date received local registrar) (b) M. M. Crowe (Registrar's signature)

**2. USUAL RESIDENCE OF DECEASED:**

(a) State (b) County

(c) City or town (If outside city or town limits write "RURAL")

(d) Street No. (If rural, give location)

(e) If foreign born, how long in U. S. A.? years.

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Month Feb day 25 year 1940 hour minute M.

21. I hereby certify that I attended the deceased from , 19, to , 19; that I last saw h alive on , 19; and that death occurred on the date and hour stated above.

| | Duration |
|---|---|
| Immediate cause of death | |
| Due to | |
| Due to | |
| Other conditions (Include pregnancy within 3 months of death) | |

Major findings:
Of operations
Of autopsy

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify)

(b) Date of occurrence

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? (Specify type of place)

While at work? (e) Means of injury

23. Signature P. F. DeMarco (M. D. or other)

Address K. C. Date signed

SUPPLEMENTARY

S-5677