

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

28939

State File No. _____

Registration District No. 470

Primary Registration District No. 5633

Registrar's No. 106

1. PLACE OF DEATH:

(a) County Lawrence

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

(c) Name of hospital or institution:
Missouri State Sanatorium
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 923 days
(Specify whether _____)

In this community 923 days
(years, months or days)

3. (a) PRINT FULL NAME Ada Lillian Raines 570

3. (b) If veteran, name war No

3. (c) Social Security No. No, no known

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Richard Raines 6. (c) Age of husband or wife if alive Unknown years

7. Birth date of deceased: August 24 1911
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day

29 ; 7 hr. min.

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

10. Usual occupation Housewife

11. Industry or business _____

12. Name Charles W. Runkle

18. Birthplace Unknown Missouri
(City, town, or county) (State or foreign country)

14. Maiden name Edna Kennison

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

16. (a) Informant E. McMichael, Record Clerk

(b) Address Missouri State Sanatorium

17. (a) Removal (b) Date thereof Sep 2, 1940
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Removal

18. (a) Signature of funeral director Stones-Kenningshaw

(b) Address Boonville, Missouri

19. (a) 9-2-40 (b) P. A. HOLMES
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Coope r

(c) City or town Boonville
(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 August day 31st
year 1940 hour 10:50 minute P M.

21. I hereby certify that I attended the deceased from February
22d, 1938, to Aug 31, 1940;
that I last saw her alive on Aug. 31, 1940;
and that death occurred on the date and hour stated above.

Immediate cause of death _____
Pneumonia Four years
duration

Due to _____

Due to _____

Other conditions (include pregnancy within 3 months of death) 77

PHYSICIAN _____

Major findings: _____

Of operations _____

Of autopsy _____

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? _____

(e) Place: _____ (Specify type of place)

While at work? 421 (e) Means of injury _____

23. Signature Edna Kennison (M., D., or Other) _____
Address Boonville Date signed 9/1/40

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

5

RECEIVED

District Health Officer No. 6,
District File Number 940-2534

Date Filed SEP 6 SEP 6 1940

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.....
....., Registered Apprentice No.....
working under my personal supervision.

Signed.....

Licensed Embalmer No.....

P. O. Address.....

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.....