

13-40  
7-13  
X-13

Registration District No. **609**

Primary Registration District No. **4363**

Registrar's No. **134**

1. PLACE OF DEATH:

(a) County **Newton**

(b) City or town **Neosho**

(c) Name of hospital or institution: **Sal. Borner Hospital**  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution **1**  
(Specify whether

In this community **1**  
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **MO** (b) County **McDonald**

(c) City or town **Goodman**  
(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

3. (a) PRINT FULL NAME **Johnnie Clifford Raines**

3. (b) If veteran, name war **✓**

3. (c) Social Security No. \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Nov** day **3**  
year **1940** hour **10** minute **0** A.M.

4. Sex **Male**

5. Color or race **White**

6. (a) Single, widowed, married, divorced **✓**

6. (b) Name of husband or wife \_\_\_\_\_

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

7. Birth date of deceased: **April 22-1937**  
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from **Oct 29**, 19**40**, to **Nov 3**, 19**40**  
and that death occurred on the date and hour stated above.

8. AGE: Years **1** Months **6** Days **11**  
If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_

Immediate cause of death: **Acute Enteritis**

Due to **Malnutrition**

Due to \_\_\_\_\_

Other conditions: \_\_\_\_\_  
(Include pregnancy within 3 months of death)

9. Birthplace **McDonald County MO**  
(City, town, or county) (State or foreign country)

10. Usual occupation \_\_\_\_\_

11. Industry or business \_\_\_\_\_

12. Name **Henry Raines**

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

14. Maiden name **Martha McDaniel**

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

16. (a) Informant **Martha Raines**

(b) Address **Goodman MO**

17. (a) **Burial** (b) Date thereof **11-4-40**  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Goodman**

18. (a) Signature of funeral director **Charles W. Miller**

(b) Address **Goodman MO**

19. (a) **Nov. 7, 1940** (b) **Uenal A. Salcedo**  
(Date received local registrar) (Registrar's signature)

Major findings: \_\_\_\_\_

Of operations **none**

Of autopsy **none**

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?  
**542**  
While at work? \_\_\_\_\_ (Specify type of place)

(e) Means of injury \_\_\_\_\_

23. Signature **Malvin P. Bourman** (M. D. or other) **11/7/40**  
Address **Neosho, MO** Date signed **Nov 7-40**

Duration \_\_\_\_\_

PHYSICIAN \_\_\_\_\_

Underline the cause to which death should be charged statistically.

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

RECEIVED

District Health Officer No. 6,

District File Number 1240-3046

Date Filed DEC 13 1949

---

---

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 the above constitutes grounds for revocation of license.)**

**If this body is not embalmed, fact should be so stated above.**