

FILED APR 8 1945
Registration District No. 275

Primary Registration District No. 3053

81
2
2
WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:
 (a) County Phelps
 (b) City or town Rolla
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
McFarland
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: in hospital or institution 1 day
 (Specify whether _____)
 In this community _____
 years, months or days)

2. USUAL RESIDENCE OF DECEASED:
 (a) State Mo (b) County Phelps
 (c) City or town Rosati
 (If outside city or town limits, write "RURAL")
 (d) Street No. _____
 (If rural, give location)
 (e) Citizen of foreign country? no (Yes or No)
 If yes, name country _____

3. (a) PRINT FULL NAME Rita S. Kaines
 3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

MEDICAL CERTIFICATION
 20. DATE OF DEATH: Month Mar day 6
 year 1943 hour 2 minute P M.
 21. I hereby certify that I attended the deceased from Mar 4
 1943 to Mar 6 1943
 that I last saw her alive on Mar 6 1943
 and that death occurred on the date and hour stated above.

4. Sex Female 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 12 30 1931
 (Month) (Day) (Year)

Immediate cause of death acute nephritis
 Due to Influenza
 Due to _____
 Other conditions _____
 (Include pregnancy within 3 months of death)
 Major findings:
 Of operations _____
 Of autopsy _____

8. AGE: Years Months Days If less than one day
11 2 6 hr. min.

9. Birthplace Alta Vista Iowa
 (City, town, or county) (State or foreign country)
 10. Usual occupation school bus

MOTHER FATHER {
 11. Industry or business _____
 12. Name August B. Kaines
 13. Birthplace Alta Vista Iowa
 (City, town, or county) (State or foreign country)
 14. Maiden name Mary O. Malley
 15. Birthplace Rosati Mo
 (City, town, or county) (State or foreign country)

PHYSICIAN
 Underline the cause to which death should be charged statistically.
330

16. (a) Informant August B. Kaines
 (b) Address Rosati Mo
 17. (a) Burial (b) Date thereof 3 8 1943
 (Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation Rosati Cem.
 18. (a) Signature of funeral director W. F. Lierhies
 (b) Address St. James Mo
 19. (a) 7-30-1943 (b) W. F. Lierhies
 (Date received local registrar) (Registrar's signature)

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?
 While at work? _____ (Specify type of place) (e) Means of injury _____
 23. Signature W. F. Lierhies (M.D. or other) MD
 Address St. James, Mo. Date signed 3-26-43

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

Carol E. Lickliter

Licensed Embalmer No. *3546*

P. O. Address *St James 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, fact should be so stated above.