

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **1377**

FILED FEB 6 1945 49

Registration District No. \_\_\_\_\_ Primary Registration District No. **1002**

Registrar's No. **374**

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

**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:  
2403 Monroe  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution no (Specify whether)

In this community 24 Yrs.  
years, months or days

**3. (a) PRINT FULL NAME** Mrs. Lillian F. 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 Wid.

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

7. Birth date of deceased 8 2 1874  
(Month) (Day) (Year)

**8. AGE:**

Years	Months	Days	If less than one day
<u>70</u>	<u>5</u>	<u>20</u>	A. hr. _____ min.

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

10. Usual occupation Housewife

11. Industry or business Housewife

12. Name Louis Pierce

13. Birthplace Monroe Co., Mo. 0  
(City, town, or county) (State or foreign country)

14. Maiden name Delia Shartzler

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

16. (a) Informant Mrs. Maydell Everett

(b) Address 2403 Monroe St., M

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-26-45  
(Month) (Day) (Year)

(c) Place: burial or cremation Mt. Washington

18. (a) Signature of funeral director P. S. Sheel

(b) Address Kansas City Mo

19. (a) 1-23-45 (Date received local registrar) (b) P. E. Brown (Registrar's signature)

**2. USUAL RESIDENCE OF DECEASED:**

(a) State Missouri (b) County Jackson

(c) City or town Kansas City 48  
(If outside city or town limits, write "RURAL")

(d) Street No. 2403 Monroe 3  
(If rural, give location)

(e) Citizen of foreign country? no (Yes or No)

If yes, name country 0

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Month 1 day 22  
year 1945 hour 10:45 minute 1 M.

21. I hereby certify that I attended the deceased from 0 1945 to 0 1945;  
that I last saw h 0 alive on 0 1945;  
and that death occurred on the date and hour stated above.

Immediate cause of death Bacterial pneumonia (Bilateral)

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

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

Other conditions 107  
(Include pregnancy within 3 months of death)

**PHYSICIAN**

Major findings: History & Inspection

Of operations \_\_\_\_\_

Of autopsy not

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? \_\_\_\_\_

While at work? \_\_\_\_\_ (Specify type of place) (e) Means of injury \_\_\_\_\_

23. Signature J. M. Walker 3 0  
(M. D. or other)

Address 1924 1/2 Poplar St Date signed 1-27-45

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**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..... *John P. Skel* .....  
Licensed Embalmer No. *3225* .....  
P. O. Address..... *15640* .....

**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.**