S. No. 2
M—8-43
7. 5-17-39
1 X37823

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED DEC 12 1945

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 38702

Registration District No. 324 Primary Registration District No. 3072 Registrar's No. 177

1. PLACE OF DEATH:

(a) County: Saline

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

(c) Name of hospital or institution: 760 South Salt Pond
(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: All his life

2. USUAL RESIDENCE OF DECEASED:

(a) State: Missouri (b) County: Saline 97

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

(d) Street No.: 760 South Salt Pond 2
(If rural, give location)

(e) Citizen of foreign country? ..... (Yes or No) 0
If yes, name country .....

3. (a) PRINT FULL NAME: William North Raines

3. (b) If veteran, name war .....

3. (c) Social Security No. 492-18-9173

4. Sex: Male 0

5. Color or race: White

6. (a) Single, widowed, married, divorced: Widowed 2

6. (b) Name of husband or wife: Rose Ella Raines

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

7. Birth date of deceased: February (Month) 14th (Day), 1874 (Year)

8. AGE: Years	Months	Days	If less than one day
71	9	9	..... hr. ..... min.

9. Birthplace: Pettis county (City, town, or county) Missouri (State or foreign country) 0

10. Usual occupation: Retired farmer

11. Industry or business .....

MOTHER FATHER

12. Name: Unknown

13. Birthplace: Unknown (City, town, or county) 4 (State or foreign country)

14. Maiden name: Unknown

15. Birthplace: Unknown (City, town, or county) 4 (State or foreign country)

16. (a) Informant: Mrs Ollie M. Craig

(b) Address: 760 S-Salt Pond, Marshall, Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: Nov. 26, 1945 (Month) (Day) (Year)

(c) Place: burial or cremation: Ridge Park cemetery

18. (a) Signature of funeral director: Campbell-Ferris

(b) Address: Marshall, Mo.

19. (a) 12-3-45 (Date received local registrar) (b) Mrs T. D. Wuthrock (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 11 day 23rd year 1945 hour ..... minute ..... M.

21. I hereby certify that I attended the deceased from 11-12-45, 1945 to 11-22-45, 1945 that I last saw him alive on 11-22-45, 1945 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Cerebral Thrombosis	12 days
Due to: Arteriosclerosis	10 yrs
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: W. Smith M. D. (M. D. or other)

Address: Marshall, Mo. Date signed 11-25-1945

1215 (Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 8,
District File Number
Date Filed 12-11-45

DEC 13 1945

DEC 19 1945

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, ~~only~~, _____, Registered Apprentice No. _____, working under my personal supervision.

Signed Jas. H. Lewis

Licensed Embalmer No. 1171

P. O. Address Marshall 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.