

FILED MAY 8 1947

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 16153

Registration District No. 341

Primary Registration District No. 6152a

Registrar's No. 73

1. PLACE OF DEATH:

(a) County Stoddard
(b) City or town Rural (Liberty)
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____
(Specify whether
in this community _____
years, months or days)

3. (a) PRINT FULL NAME Cora Lee Holmes Rainey

3. (b) If veteran, name war _____
3. (c) Social Security No. 376-12-3156

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

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if

7. Birth date of deceased March 19 1895
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	52	0	22	hr. min.

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

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER

12. Name Asa Van Buren Holmes

13. Birthplace Green County Illinois
(City, town, or county) (State or foreign country)

14. Maiden name Vice Caroline Wells
(City, town, or county) (State or foreign country)

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

16. (a) Informant Ira Holmes

(b) Address Dexter, Mo. R.F.D. # 1.

17. (a) Burial (b) Date thereof 4-13-47
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Pleasant Valley

18. (a) Signature of funeral director Strickland-Rainey

(b) Address Dexter, Missouri

19. (a) 4/23-47 (b) Margaret Orrett
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Stoddard 103
(c) City or town Rural
(If outside city or town limits, write "RURAL")
(d) Street No. R.F.D. # 1, Dexter, Missouri
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 10
year 1947 hour 5 minute 20 P.M.

21. I hereby certify that I attended the deceased from Dec. 18 - 1946, to Sept. 7 - 10 1947
that I last saw her alive on 3-27-1947
and that death occurred on the date and hour stated above.

Immediate cause of death second day pneumonia Duration 4 hrs.
Due to Chinacetic Inanition

Due to _____
Other conditions (Include pregnancy within 3 months of death) _____

Major findings: Of operations 7-7-47
Of autopsy no
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) no
(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 S. S. Rainey (M. D. or other) _____
Address Dexter Mo Date signed 4-10-47

District File Number 547
Date Filed 5-6-47

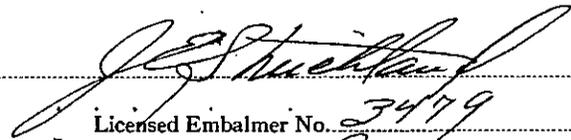
STATEMENT BY LICENSED EMBALMER

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. 3479

P. O. Address Dexter, 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.

Registration District No. 341 Primary Registration District No. 61529

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

3. (a) PRINT FULL NAME Core L. H. Ranney
3. (b) If veteran, name war..... 3. (c) Social Security No.....

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

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

7. Birth date of deceased March 19 (Month) (Day) (Year)

8. AGE: Years 52 Months 0 Days 0 (If less than one day, hr. min.)

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

10. Usual occupation Employed at Cafe.

MOTHER FATHER { 12. Name.....
13. Birthplace..... (City, town, or county) (State or foreign country)
14. Maiden name.....
15. Birthplace..... (City, town, or county) (State or foreign country)

16. (a) Informant.....
(b) Address.....

17. (a) (Burial, cremation, or removal)..... (b) Date thereof..... (Month) (Day) (Year)
(c) Place: burial or cremation.....

18. (a) Signature of funeral director.....
(b) Address.....

19. (a) (Date received local registrar)..... (b) (Registrar's signature).....

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

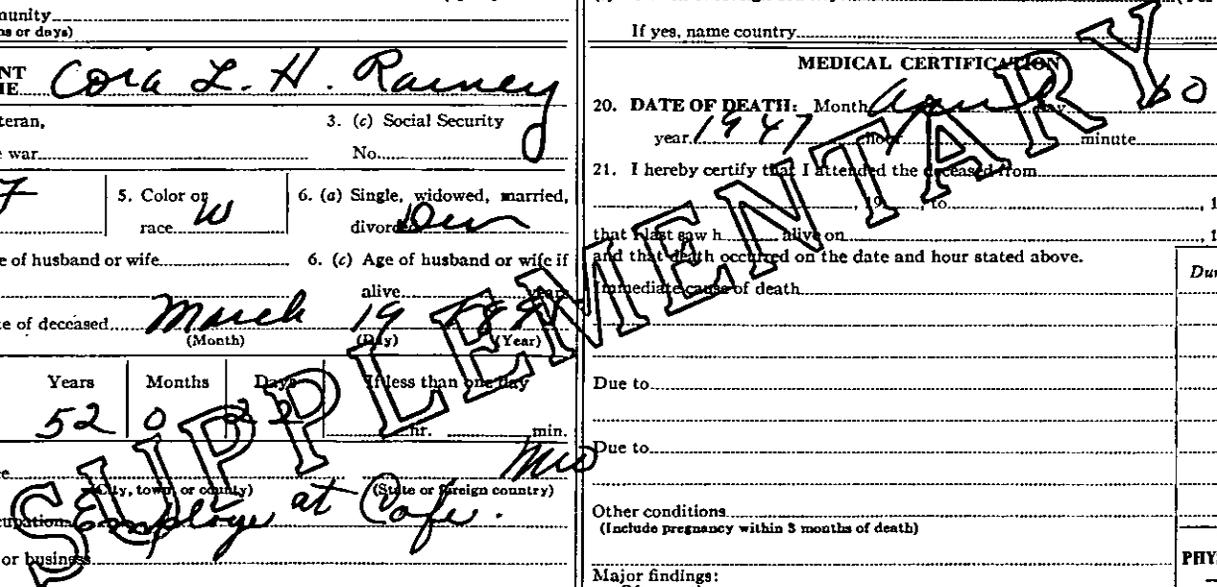
MEDICAL CERTIFICATION
20. DATE OF DEATH: Month April year 1947 day 10 minute 0 M.
21. I hereby certify that I attended the deceased from..... to....., 19.....
that I last saw him..... alive on....., 19.....
and that death occurred on the date and hour stated above.
Immediate cause of death.....

Due to.....
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?
While at work?..... (Specify type of place) (e) Means of injury.....

23. Signature..... (M. D. or other).....
Address..... Date signed.....



WHILE FILLING IN USE UNFADING BLACK INK - MAKE A PERMANENT RECORD

16153