

FILED MAY 11 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 14076
Registrar's No. 3926

318

1003

BIRTH NO. _____ REG. DIST. NO. _____ PRIMARY REG. DIST. NO. _____

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE MISSOURI b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN ST. LOUIS		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN ST. LOUIS	
c. LENGTH OF STAY (in this place)		d. STREET ADDRESS (If rural, give location) 3601 LINDELL BLVD.	
d. FULL NAME OF HOSPITAL OR INSTITUTION 3601 LINDELL BLVD.			

3. NAME OF DECEASED (Type or Print)	a. (First) ONEY	b. (Middle) CARSTAFFEN	c. (Last) RAINES.	4. DATE OF DEATH (Month) (Day) (Year) MAY 2, 1949
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5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) MARRIED.	8. DATE OF BIRTH Dec. 13, 1876.	9. AGE (In years) (Months) (Days) (Hours) (Min.) 72 4 19
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) PHYSICIAN and	10b. KIND OF BUSINESS OR INDUSTRY SURGEON.	11. BIRTHPLACE (State or foreign country) EMERSON, MISSOURI.	12. CITIZEN OF WHAT COUNTRY? U.S.A.
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13a. FATHER'S NAME ALPHEUS RAINES.	13b. MOTHER'S MAIDEN NAME SARAH McPIKE.	14. NAME OF HUSBAND OR WIFE FLORENCE RAINES.
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give way or dates of service) YES W.W. I.	16. SOCIAL SECURITY NO. NO	17. INFORMANT'S SIGNATURE OR NAME Florence Raines, 3601 Lindell Blvd.,	ADDRESS
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cancer of Stomach		INTERVAL BETWEEN ONSET AND DEATH 1 year
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____		
	II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		

19a. DATE OF OPERATION June 1948	19b. MAJOR FINDINGS OF OPERATION Cancer of Stomach	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) H/lo MO
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (m.)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? 157A
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22. I hereby certify that I attended the deceased from **May 10, 1948**, to **May 2, 1949**, that I last saw the deceased alive on **April 26, 1949**, and that death occurred at **5:00 A.M.**, from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) Joseph W. Larmore M.D.	23b. ADDRESS 3725 Washington Ave	23c. DATE SIGNED 5/2/49
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24a. BURIAL, CREMATION, REMOVAL (Specify) Interment.	24b. DATE 5/4/49.	24c. NAME OF CEMETERY OR CREMATORY Valhalla Cemetery.	24d. LOCATION (City, town, or county) (State) St. Louis County, Missouri.
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DATE RECD BY LOCAL MAY 2 1949	REGISTRAR'S SIGNATURE J. B. Sasater	25. FUNERAL DIRECTOR'S SIGNATURE C.R. LUPTON & SONS	ADDRESS 7233 DELMAR BLVD.
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WRITE PLAINLY—USING UNFAADING BLACK INK—MAKE A PERMANENT RECORD

19

SEP 27 1949

MAY 18 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 _____

Student Embalmer No. _____

working under my personal supervision.

Signed Arnold W. Schoene

Signed _____
Student Embalmer

Licensed Embalmer No. 3864

P. O. Address St. Louis, 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.