

FILED JUL 8 1949

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 19742  
2653

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 149 PRIMARY REG. DIST. NO. 1002 Registrar's No. \_\_\_\_\_

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

1. PLACE OF DEATH a. COUNTY <b>Jackson</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>Missouri</b> b. COUNTY <b>Jackson</b>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>Kansas City</b>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>Independence</b>	
c. LENGTH OF STAY (In this place) <b>4 days</b>		d. STREET ADDRESS (If rural, give location) <b>414 W. Lexington</b>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>Osteopathic Hospital</b>			

3. NAME OF DECEASED (Type or Print) a. (First) <b>Abbie</b> b. (Middle) <b>Laura</b> c. (Last) <b>Rawlins</b>			4. DATE OF DEATH (Month) (Day) (Year) <b>June 16, 1949</b>		
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5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED, (Specify) <b>divorced</b>	8. DATE OF BIRTH <b>Dec. 2, 1877</b>	9. AGE (In years last birthday) <b>71</b>	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>self employed</b>	11. BIRTHPLACE (State or foreign country) <b>Blair, Nebr.</b>	12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
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13a. FATHER'S NAME <b>Alfred Pease</b>	13b. MOTHER'S MAIDEN NAME <b>Unknown</b>	14. NAME OF HUSBAND OR WIFE <b>none (divorced)</b>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>	16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <b>none</b>	17. INFORMANT'S SIGNATURE OR NAME <b>Mrs. Ohla Stagg</b>	ADDRESS <b>Independence, Mo.</b>
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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.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Coronary Occlusion</b>		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <b>Cardiac decompensation myocarditis</b> DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <b>Diabetes M.</b>			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION <b>4201</b>	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)
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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
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22. I hereby certify that I attended the deceased from **3/7/49** to **6/16/49**, that I last saw the deceased alive on **6/16/49**, and that death occurred at **6:00 p.m.**, from the causes and on the date stated above.

23a. SIGNATURE <b>M. A. Whellons</b>	23b. ADDRESS <b>Independence Mo</b>	23c. DATE SIGNED <b>6-17-49</b>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	24b. DATE <b>6-20-49</b>	24c. NAME OF CEMETERY OR CREMATORY <b>Mound Grove</b>	24d. LOCATION (City, town, or county) (State) <b>Independence, Mo.</b>
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DATE REC'D BY LOCAL REG. <b>6-20-49</b>	REGISTRAR'S SIGNATURE <b>Seraldine Holmes</b>	25. FUNERAL DIRECTOR'S SIGNATURE <b>Geo. Carson</b>	ADDRESS <b>Independence, Mo.</b>
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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 \_\_\_\_\_

Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Signed *Walter Carson*  
Licensed Embalmer No. *4199*  
P. O. Address *Indy. Mo*

Signed \_\_\_\_\_  
Student Embalmer

**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.