

FILED FEB 27 1950

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

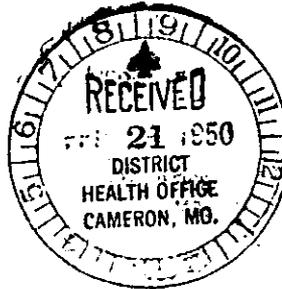
State File No. 5360

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

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 187 PRIMARY REG. DIST. NO. 5703 Registrar's No. 20

1. PLACE OF DEATH a. COUNTY <u>Livingston</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Livingston</u>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Chula-Rural-Medicine</u> LENGTH OF STAY (In this place) <u>36 years</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Chula-Rural-Medicine</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION: <u>R#2</u>		d. STREET ADDRESS (If rural, give location) <u>R#2</u> <u>05711</u>	
3. NAME OF DECEASED (Type or Print) a. (First) <u>Richard</u> b. (Middle) <u>Thomas</u> c. (Last) <u>Raney</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>Feb. 5 1950</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>4-4-1885</u>
9. AGE (In years last birthday) <u>64</u>		IF UNDER 1 YEAR Months <u>10</u> Days _____	IF UNDER 24 HRS. Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY _____	11. BIRTHPLACE (State or foreign country) <u>Chula Missouri</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13a. FATHER'S NAME <u>James C. Raney</u>	
13b. MOTHER'S MAIDEN NAME <u>Fannie Turner</u>		14. NAME OF HUSBAND OR WIFE <u>Ins Noble Raney</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>✓</u>	17. INFORMANT'S SIGNATURE OR NAME <u>Ina M. Raney</u> ADDRESS <u>Chula Mo</u>
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, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Chronic Hypertension</u> INTERVAL BETWEEN ONSET AND DEATH _____ ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>hypertension</u> DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>443X</u>	
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		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) _____	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____		21e. INJURY OCCURRED WHILE AT <input type="checkbox"/> WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR? _____			
22. I hereby certify that I attended the deceased from <u>April 26, 1947</u> to <u>Feb 5, 1950</u> , that I last saw the deceased alive on <u>Jan 31, 1950</u> , and that death occurred at <u>11:45 AM</u> m., from the causes and on the date stated above.			
23a. SIGNATURE (Degree or title) <u>Frank F. Gale M.D.</u>		23b. ADDRESS <u>Chillicothe Mo</u>	
23c. DATE SIGNED <u>2-6-50</u>		24. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	
24b. DATE <u>2-7-1950</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Plainview Cemetery</u>	
24d. LOCATION (City, town, or county) (State) <u>Chula MO</u>		DATE REC'D BY LOCAL REG. <u>2-6-50</u>	
REGISTRAR'S SIGNATURE <u>Francis B. Neill</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>E.T. Robertson</u> ADDRESS <u>Funeral Home, Chula Mo</u>	



**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.....

*John M Robertson*

Signed.....  
Student Embalmer

Licensed Embalmer No. *4388*

P. O. Address *Laredo 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.