

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 11502

FILED APR 27 1951

BIRTH NO.		REG. DIST. NO. 27		PRIMARY REG. DIST. NO. 5000		Registrar's No. 30	
1. PLACE OF DEATH a. COUNTY <u>Bates</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Bates</u>			
b. CITY (If outside corporate limits, write RURAL and give township) <u>Butler</u>		c. LENGTH OF STAY (in this place) <u>1 day</u>		c. CITY (If outside corporate limits, write RURAL and give township) <u>Rural - Elkhart</u>		0070	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Butler Hospital</u>				d. STREET ADDRESS (If rural, give location) <u>7 miles west 3 miles south of Adrian</u>			
3. NAME OF DECEASED (Type or Print) a. (First) <u>John Breckenridge</u>		b. (Middle)		c. (Last) <u>Rabourn</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>4-17-51</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>		8. DATE OF BIRTH <u>5-18-1858</u>		9. AGE (In years last birthday) <u>92</u>	10. UNDER 1 YEAR Months <u>10</u> Days <u>29</u>
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>Grant City Missouri</u>		12. CITIZEN OF WHAT COUNTRY?	
13a. FATHER'S NAME <u>Isaac Newton Rabourn</u>			13b. MOTHER'S MAIDEN NAME <u>Sarah Wilkerson</u>		14. NAME OF HUSBAND OR WIFE <u>Etta Rabourn</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>No</u>		17. INFORMANT'S SIGNATURE OR NAME <u>O. E. Rabourn</u>		ADDRESS	
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>Cerebral hemorrhage</u> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Age related Schisms</u> DUE TO (c) II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>none</u>				INTERVAL BETWEEN ONSET AND DEATH	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION <u>331X</u>				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 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>4:16</u> , 19 <u>51</u> , to <u>4:16</u> , 19 <u>51</u> , that I last saw the deceased alive on _____, 19____, and that death occurred at <u>5:55 A.M.</u> , from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) <u>E. E. Robinson M.D.</u>				23b. ADDRESS <u>Adrian Mo.</u>		23c. DATE SIGNED <u>4-17-51</u>	
24a. BURIAL, CREMATION, REMOVAL, OR DISPOSITION <u>Burial</u>		24b. DATE <u>4-19-51</u>	24c. NAME OF CEMETERY OR CREMATORIUM <u>Scott Cemetery</u>		24d. LOCATION (City, town, or county) (State) <u>Bates County Mo.</u>		
DATE REC'D BY LOCAL REG. <u>Apr 20-1951</u>		REGISTRAR'S SIGNATURE <u>Mendall Wray</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Ereath & Six</u>		ADDRESS <u>Adrian, Mo</u>	

RECEIVED 4-26-51

DISTRICT HEALTH OFFICE No. 3

District File Number _____

Date Filed 4-26-51

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. 3650

working under my personal supervision.

Student _____
Student Embalmer

Signed _____

Licensed Embalmer No. 3650

P. O. Address Adrian 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.