No. 300
10.48

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

1030
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FILED FEB 10 1953

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 4519

BIRTH NO. _____ REG. DIST. NO. 340 PRIMARY REG. DIST. NO. 615 Registrar's No. 3

1. PLACE OF DEATH
a. COUNTY: Stoddard Co
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Elk. (Rural)
c. LENGTH OF STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location):

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Missouri
b. COUNTY: Stoddard
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Elk. Rural) 1030
d. STREET ADDRESS (If rural, give location): 0

3. NAME OF DECEASED (Type or Print)
a. (First): Betty
b. (Middle):
c. (Last): Rainey

4. DATE OF DEATH: (Month) Feb. (Day) 2, (Year) 1953

5. SEX: F

6. COLOR OR RACE: Col

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): married

8. DATE OF BIRTH: 1850

9. AGE (In years last birthday): 102 | IF UNDER 1 YEAR Months: | Days: | IF UNDER 24 HRS. Hours: | Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Hays Co. Penn

12. CITIZEN OF WHAT COUNTRY?: U.S.a.

13a. FATHER'S NAME: unknown

13b. MOTHER'S MAIDEN NAME: unknown

14. NAME OF HUSBAND OR WIFE: Will Rainey

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): —
(If yes, give war or dates of service): —

16. SOCIAL SECURITY NO.: —

17. INFORMANT'S SIGNATURE OR NAME, ADDRESS: Ed Robinson, Lavalle, Mo

MEDICAL CERTIFICATION

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): Cerebral Hemorrhage — 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):

DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. 331X

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? YES ☐ NO ☐

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) m.:

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?:

22. *I hereby certify that I attended the deceased from* 1-13, 1953, *to* Feb 2, 1953 *that I last saw the deceased alive on* 1-19, 1953, *and that death occurred at* 9:00 a.m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Dr. Geo. W. Lunsford M.D.

23b. ADDRESS: Parma Mo.

23c. DATE SIGNED: 2/2/53

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: Feb 8, 1953

24c. NAME OF CEMETERY OR CREMATORY: Pleasant Ridge Cem. No. 9

24d. LOCATION (City, town, or county) (State): Blytheville, Ark.

DATE REC'D BY LOCAL REG.: 2-6-53

REGISTRAR'S SIGNATURE: Velma V. Jenkins 499-0

25. FUNERAL DIRECTOR'S SIGNATURE, ADDRESS: Ernest Caston, Blytheville, Ark.

(Licensed Embalmer's Statement on Reverse Side)

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.

Student .....
Student Embalmer

Signed_____

Licensed Embalmer No._____

P. O. Address_____

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.