

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

2295

3053

State File No.

FILED FEB 10 1954

275

BIRTH NO. _____ REG. DIST. NO. _____ PRIMARY REG. DIST. NO. ~~4489~~ Registrar's No. 21

1. PLACE OF DEATH a. COUNTY <u>Mo. Hks</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE <u>Missouri</u> b. COUNTY <u>CRAWFORD</u>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Rolla</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Cuba, Mo.</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Mo. Hks. P. Mem. Hosp</u>		d. STREET ADDRESS (If rural, give location) <u>IV. R. # 2</u>	

3. NAME OF DECEASED (Type or Print) a. (First) <u>Ruth</u> b. (Middle) <u>FRANCES</u> c. (Last) <u>GAINES</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>JAN - 26 - 1954</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>4-18-1892</u>	9. AGE (In years last birthday) <u>61</u> IF UNDER 1 YEAR Months <u>9</u> Days <u>16</u> IF UNDER 1 HR. Hours <u>16</u> Min.
--------------------	-------------------------------	-----------------------------------------------------------------------	-----------------------------------	------------------------------------------------------------------------------------------------------------------------------

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	11. BIRTHPLACE (State or foreign country) <u>St. Louis Mo.</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
----------------------------------------------------------------------------------------------------------	-----------------------------------------------	----------------------------------------------------------------	--------------------------------------------

13a. FATHER'S NAME <u>John Hoke</u>	13b. MOTHER'S MAIDEN NAME <u>Emma Hicks</u>	14. NAME OF HUSBAND OR WIFE <u>Cecil Gaines</u>
-------------------------------------	---------------------------------------------	-------------------------------------------------

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or date of service) <u>None</u>	16. SOCIAL SECURITY NO. <u>None</u>	17. INFORMANT'S SIGNATURE OR NAME <u>Cecil Gaines</u> ADDRESS <u>Ap. 2, Cuba 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, ashenia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH <u>2 hrs.</u> <u>16 hrs.</u> <u>15 yrs.</u>
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Cardio-respiratory failure</u>		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Invasive Arteriosclerosis</u> DUE TO (c) <u>Essential Hypertension</u>		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			

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) (Min.)	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 Jan 25 1954 to Jan 26 1954, that I last saw the deceased alive on Jan 26 1954, and that death occurred at 1:30 p.m., from the causes and on the date stated above.

23a. SIGNATURE (Type or Print) <u>H. Elders M.D.</u>	23b. ADDRESS <u>Cuba Mo.</u>	23c. DATE SIGNED <u>1-27-1954</u>
------------------------------------------------------	------------------------------	-----------------------------------

24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	24b. DATE <u>1-29-1954</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Kindred Cemetery</u>	24d. LOCATION (City, town, or county) (State) <u>Cuba Mo.</u>
---------------------------------------------------------	----------------------------	------------------------------------------------------------	---------------------------------------------------------------

DATE RECD BY LOCAL REG. <u>Jan 27 1954</u>	REGISTRAR'S SIGNATURE <u>[Signature]</u>	FEDERAL DIRECTOR'S SIGNATURE <u>[Signature]</u> ADDRESS <u>Cuba Mo.</u>
--------------------------------------------	------------------------------------------	-------------------------------------------------------------------------

(Licensed Embalmer's Statement on Reverse Side)

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

County File Number _____
Date Filed 2-2-54

REV 8 8 1950

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 _____

working under my personal supervision.

Student Embalmer No. _____

Student
Student Embalmer

Signed Paul A. Sharrick
Licensed Embalmer No. 3472
P. O. Address Suba, 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.