

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

4671

State File No. _____
Registrar's No. 16

FILED FEB 24 1954
BIRTH NO. _____ REG. DIST. NO. 140 PRIMARY REG. DIST. NO. 3027

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

1. PLACE OF DEATH a. COUNTY <u>Howard</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Howard</u>	
b. CITY (If outside corporate limits, write RURAL and give township) <u>Fayette</u>		c. CITY (If outside corporate limits, write RURAL and give township) <u>Glasgow</u>	
c. LENGTH OF STAY (In days) <u>22 days</u>		d. STREET ADDRESS (If rural, give location) <u>0450</u> <u>0</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Fayette Conv. Home</u>			

3. NAME OF DECEASED (Type or Print) <u>Robert WARREN RAINES</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>Feb. 16, 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>Oct. 17, 1873</u>		9. AGE (In years) (Months) (Days) (Hours) (Min.) <u>80</u>	

10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired) <u>Telegraph Operator</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Railroad</u>		11. BIRTHPLACE (State or foreign country) <u>Illinois</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13a. FATHER'S NAME <u>John Raines</u>		13b. MOTHER'S MAIDEN NAME <u>Thobe Ireland</u>		14. NAME OF HUSBAND OR WIFE <u>Lillie McClinton Raines</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>Not available</u>		17. INFORMANT'S SIGNATURE OR NAME <u>Mrs. Roberta Purdy</u>				ADDRESS <u>Glasgow, 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, asthenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH <u>1 hr</u>	
1. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Cerebral Occlusion</u>		ANTECEDENT CAUSES							
		Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last.							
		DUE TO (b) <u>Carcinoma prostate</u>							
		DUE TO (c)							
		II. OTHER SIGNIFICANT CONDITIONS							
		Conditions contributing to the death but not related to the disease or condition causing death.							

19a. DATE OF OPERATION <u>—</u>		19b. MAJOR FINDINGS OF OPERATION <u>—</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) <u>177 X</u>	
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 Feb 14, 1954 to Feb 16, 1954, that I last saw the deceased alive on Feb 16, 1954, and that death occurred at 5:30 p.m., from the causes and on the date stated above.

23a. SIGNATURE <u>M. Keuch M.D.</u>		(Degree or title)		23b. ADDRESS <u>Fayette, Mo.</u>		23c. DATE SIGNED <u>2/21/54</u>	
--	--	-------------------	--	-------------------------------------	--	------------------------------------	--

24a. BURIAL, CREMATION, REMOVAL (Specify)		24b. DATE <u>Feb. 18, 1954</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Washington</u>		24d. LOCATION (City, town, or county) (State) <u>Glasgow, Mo.</u>	
---	--	-----------------------------------	--	---	--	--	--

DATE REC'D BY LOCAL REG. <u>2-21-54</u>		REGISTRAR'S SIGNATURE <u>Mary L. Sull</u>		FUNERAL DIRECTOR'S SIGNATURE <u>Wudaley</u>		ADDRESS <u>Fremont, Glasgow, Mo.</u>	
--	--	--	--	--	--	---	--

APR 12 1954

MAR 8 1954

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.

Signed *Ed W. Remond*

Signed.....
Student Embalmer

Licensed Embalmer No. *3978*

P. O. Address *Glasgow N.S.*

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.