

FILED SEP 7 1956

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATHState File No. **29585**

BIRTH NO. _____		REG. DIST. NO. <b>391</b>		PRIMARY REG. DIST. NO. <b>6153</b>		Registrar's No. <b>20</b>	
1. PLACE OF DEATH a. COUNTY <b>Stodda rd</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>Missouri</b> b. COUNTY <b>Stoddard</b>			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>Rural (Pike Twp)</b>		c. LENGTH OF STAY (In this place)		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>Rural (Pike Twp)</b>		d. STREET ADDRESS (If rural, give location) <b>1030</b> <b>R.F.D. #2, Essex, Mo.</b>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>Residence</b>							
3. NAME OF DECEASED (Type or Print)		a. (First) <b>Elvis</b>		b. (Middle) <b>Benton</b>		c. (Last) <b>Gaines</b>	
4. DATE OF DEATH		5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>married</b>	
8. DATE OF BIRTH <b>Dec. 7, 1889</b>		9. AGE (In years last birthday) <b>66</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Engineer</b>		11. BIRTHPLACE (City and State or Foreign Country) <b>Sherry, Mo. Stoddard, Co.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U. S.</b>		13a. FATHER'S NAME <b>Frank Gaines</b>		13b. MOTHER'S MAIDEN NAME <b>Hill</b>		14. NAME OF HUSBAND OR WIFE <b>Bessie Gaines</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no none</b>		16. SOCIAL SECURITY NO. <b>327-09-9652A</b>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <b>Albert Gaines, Essex, R. 2</b>			
18. CAUSE OF DEATH Enter only one operation 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) <b>Cerebral Hemorrhage</b> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <b>Arteriosclerosis, sinus</b> DUE TO (c) II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <b>Miniplegia yrs</b>				INTERVAL BETWEEN ONSET AND DEATH <b>1 day</b> <b>years</b> <b>years</b>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		<b>331x</b>	
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 <b>Oct 1955</b> , to <b>Aug 8, 1956</b> , that I last saw the deceased alive on <b>Aug 9, 1956</b> , and that death occurred at <b>10:30 AM</b> , from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) <b>Stephen Fairbairn MD</b>				23b. ADDRESS <b>Bloomfield Mo</b>		23c. DATE SIGNED <b>8-23-56</b>	
24a. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24b. DATE <b>8-10-56</b>		24c. NAME OF CEMETERY OR CREMATORY <b>Hill</b>		24d. LOCATION (City, town, or county) (State) <b>Stoddard County, Mo.</b>	
DATE REC'D BY LOCAL REG. <b>8/28/56</b>		REGISTRAR'S SIGNATURE <b>Dexter Moore</b>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>Strickland-Rainey Dexter, Mo.</b>			

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

1956  
OCT 4

1956  
OCT 2

**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 *Lucille Rainey*

Licensed Embalmer No. 4983

P. O. Address *Sevier, 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.