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 Doctor, coroner, etc. must use any standard nomenclature in report for the symptoms and conditions of natural causes.  
 diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes.  
 USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE  
 M. B. Casebolt

FILED FEB 18 1957

THE DIVISION OF HEALTH OF MISSOURI  
 STANDARD CERTIFICATE OF DEATH

4936  
 STATE FILE NUMBER

382  
 Registrar's No.

Registration District No. 149 Primary Registration District No. 1002

|  |  |  |   |
|--|--|--|---|
| 1. PLACE OF DEATH<br>a. COUNTY <b>JACKSON</b>  |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>MISSOURI</b> b. COUNTY <b>JACKSON</b> |   |
| b. CITY (If outside corporate limits, give TOWNSHIP only)<br>OR<br>TOWN <b>KANSAS CITY</b>   |  | Inside Limits<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>   | c. CITY OR TOWN <b>KANSAS CITY</b><br>898 |
| c. FULL NAME OF SERVICE STATION (If in institution) Length of stay in lb<br>HOSPITAL OR INSTITUTION <b>2445 PROSPECT</b> <b>20 YEARS</b> |  | d. STREET ADDRESS (If outside, give location)<br><b>3605 EAST 75th ST.</b>   |   |

|   |                                  |   |  |  |   |
|---|----------------------------------|---|--|--|---|
| 3. NAME OF DECEASED<br>(Type or print)<br>First <b>John</b> Middle <b>E.</b> Last <b>RAYNES</b>                               |                                  |   | 4. DATE OF DEATH<br>Month <b>JAN</b> Day <b>22</b> Year <b>1957</b>  |  |   |
| 5. SEX<br><b>MALE</b>   | 6. COLOR OR RACE<br><b>White</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>MAY 24, 1891</b>                              | 9. AGE (In years last birthday)<br><b>65</b> |   |
| 10a. USUAL OCCUPATION (Give kind of work done during working life, even if retired)<br><b>COAL MINER</b>                      |                                  | 10b. KIND OF BUSINESS OR INDUSTRY   | 11. BIRTHPLACE (City and state or country)<br><b>HESSA, MISSOURI</b> |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b> |
| 13. FATHER'S NAME<br><b>JAMES RAYNES</b>  |                                  |   | 14. MOTHER'S MAIDEN NAME<br><b>SARAH DARNELL</b>                     |  |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown) (If yes, give war or dates of service)<br><b>YES WWI</b> |                                  | 16. SOCIAL SECURITY NO.<br><b>496-09-3952</b>   | 17. INFORMANT<br>Address<br><b>MAY RAYNES 3605 EAST 75th ST.</b>     |  |   |

|   |                                       |  |
|---|---------------------------------------|--|
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cancer of esophagus</b> |                                       | INTERVAL BETWEEN ONSET AND DEATH<br><b>1 hr</b><br><b>3 yrs</b><br><b>4201</b>         |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.  | DUE TO (b) <b>Anterior tubercles.</b> |  |
|   | DUE TO (c) <b>rupture</b>             |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (n).                          |                                       | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |

|   |  |   |
|---|--|---|
| 20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/> | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)<br><b>0</b> |   |
| 20c. TIME OF INJURY<br>Hour _____ Month _____ Day _____<br>a. m. _____ p. m. _____                        |  |   |
| 20d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | 20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                 | 20f. CITY, TOWN, OR LOCATION COUNTY STATE |

|  |                                       |                                    |
|--|---------------------------------------|------------------------------------|
| 21. I attended the deceased from <b>Oct 26, 1956</b> and last saw her alive on <b>1-22-57</b> .<br>Death occurred at <b>7:10 p.m.</b> on the date stated above; and to the best of my knowledge, from the causes stated. |                                       |                                    |
| 22a. SIGNATURE<br><b>M. B. Casebolt MD</b>   | 22b. ADDRESS<br><b>8092 Baltimore</b> | 22c. DATE SIGNED<br><b>1-23-57</b> |

|  |                                   |   |  |
|--|-----------------------------------|---|--|
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>BURIAL</b> | 23b. DATE<br><b>JAN. 25, 1957</b> | 23c. NAME OF CEMETERY OR CREMATORY<br><b>MEMORIAL PARK CEMETERY</b> | 23d. LOCATION (City, town, or county) (State)<br><b>KANSAS CITY MISSOURI</b> |
| 24. FUNERAL DIRECTOR<br><b>D.W. NEWCOMER'S JONES BRUSH</b> |                                   | ADDRESS<br><b>1331 R.C.M.O. CREEK BLVD</b>                          | 25. DATE RECD. BY LOCAL REG.<br><b>1-25-57</b>                               |
|  |                                   |   | 26. REGISTRAR'S SIGNATURE<br><b>neva minshall</b>                            |

REB 12 1958

**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.....  
Signature of Student Embalmer

Signed *Paul R. Williamson*

Licensed Embalmer No. *500*

P. O. Address *Overland Park Kan*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (to comply with the above constitutes grounds for revocation of license)  
If embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above..