

Health,
& Welfare
S. Public
th Service

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-018448

STATE FILE NUMBER

FILED JUN 5 1958

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 2512

S. 300
v. 1-57

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

B. I. Burns

1. PLACE OF DEATH a. COUNTY Jackson		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Jackson	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Kansas City		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN Kansas City Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Gen'l Hosp. 1 #		Length of stay in lb 30 yrs	d. STREET ADDRESS (If outside, give location) 2915 Forest Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Roy Middle F. Last Raines			4. DATE OF DEATH Month May Day 17 Year 1958
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6-27-88
9. AGE (In years last birthday) 69		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cater		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) Ozawkie, Kansas
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13a. FATHER'S NAME William Raines	
13b. MOTHER'S MAIDEN NAME Anna Johnson		14. NAME OF HUSBAND OR WIFE none	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? NO (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. -	17. INFORMANT Address Mrs. Maude Parker, Ozawkie, Kans.
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of Prostate			INTERVAL BETWEEN ONSET AND DEATH 197 X
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Pyelonephritis and Uremia			
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" 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.)		
20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.			
20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE WORK <input type="checkbox"/> 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 3-5-58 to 5-17-58 and last saw her alive on May 17, 1958 Death occurred at 11:10 P.M. on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE B. I. Burns, M.D. (Degree or title)		22b. ADDRESS Kansas City, Mo.	
22c. DATE SIGNED			
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 5-17-58	23c. NAME OF CEMETERY OR CREMATORY Ozawkie, Kansas Cemetery	23d. LOCATION (City, town, or county) (State) Ozawkie, Kansas
24. FUNERAL DIRECTOR D. W. Newcomb & Sons ADDRESS K.C., Mo.		25. DATE RECD. BY LOCAL REG. 5-17-58	26. REGISTRAR'S SIGNATURE Neva Minshall

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 *Edward M. St...*

Licensed Embalmer No. *4452*

P. O. Address *K.C. 10 M*

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.