

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-011297

STATE FILE NUMBER

Registration District No. 2258

Health,
Welfare
Public
Service

300
-57
3
6

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
MEDICAL CERTIFICATION
All diseases in Part I must be causally related.

MAR 17 1959 Registration District No. _____ Primary Registration District No. _____ Registrar No. 2258

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		c. CITY OR TOWN St. Louis	
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) 4 HOSPITAL OR INSTITUTION Hamilton Nursing Home		Length of stay in lb 2wks	
d. STREET ADDRESS 3810 Folsom		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Emmett J Rainey			4. DATE OF DEATH Month Day Year Mar 4 1959
5. SEX Male ^o	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 15 1883
9. AGE (In years last birthday) 75	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Packer	10b. KIND OF BUSINESS OR INDUSTRY J.C. Penny Co	11. BIRTHPLACE (City and state or country) Visious Springs Mo ^o	12. CITIZEN OF WHAT COUNTRY? USA
13a. FATHER'S NAME John C. Rainey		13b. MOTHER'S MAIDEN NAME Martha Hawkins	14. NAME OF HUSBAND OR WIFE Katie Been Rainey
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO	16. SOCIAL SECURITY NO. 493-07-2813	17. INFORMANT Katie Rainey 3810 Folsom	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Metastatic Carcinoma of Lungs</i>			INTERVAL BETWEEN ONSET AND DEATH 4 months
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ 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"/> 2
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 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 <i>May 31, 1958</i> to <i>March 4, 1959</i> and last saw ^{her} him alive on <i>February 27, 1959</i> Death occurred at <i>5:30 A</i> m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <i>Harvey Walker, Jr. M.D.</i>		22b. ADDRESS <i>462 N. Taylor St. Louis 8 Mo.</i>	22c. DATE SIGNED <i>Mar. 4 1959</i>
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE Mar 6, 59	23c. NAME OF CEMETERY OR CREMATORY Baldwin	23d. LOCATION (City, town, or county) (State) Baldwin Ill
24. FUNERAL DIRECTOR E.J. Schnur 3125 Lafayette		25. DATE RECD. BY LOCAL REG. MAR 4 '59	26. REGISTRAR'S SIGNATURE <i>Roan Smith, M.D.</i>

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 *Thomas R. Fenwick*

Licensed Embalmer No. *3793*

P. O. Address *3125 Lafayette*

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.