

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-021014

STATE FILE NUMBER

FILED JUL 7 1959 Registration District No. 128 Primary Registration District No. 2000 Registrar's No. 693C

S. 300
1-57

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1. PLACE OF DEATH a. COUNTY GREENE		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Greene	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN SPRINGFIELD		c. CITY OR TOWN Springfield	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION DEARBORNE HOSPITAL		d. STREET ADDRESS (If outside, give location) 1026 S. Ferguson	

3. NAME OF DECEASED (Type or print) JAMES R RAINS			4. DATE OF DEATH 6-24-1959		
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5. SEX Male	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 8-14-1891	9. AGE (In years last birthday) 67	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman	10b. KIND OF BUSINESS OR INDUSTRY Grocery	11. BIRTHPLACE (City and state or country) Dallas Co Mo	12. CITIZEN OF WHAT COUNTRY? U.S.A.
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13a. FATHER'S NAME Joshua Rains	13b. MOTHER'S MAIDEN NAME Lucinda Frazer	14. NAME OF HUSBAND OR WIFE Alma
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15. HAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) UN KNOWN	16. SOCIAL SECURITY NO. Unknown	17. INFORMANT Springfield Alma Rains 1026 Ferguson Mo
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Rheumatic heart disease with mitrostenosis and aortic insufficiency		INTERVAL BETWEEN ONSET AND DEATH Unknown
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) 410X		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.)
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20c. TIME OF INJURY Hour _____ 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
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21. I attended the deceased from 1952 , to 6/24/59 and last saw her alive on June 17, 1959 Death occurred at 6:15 P.M. on the date stated above; and to the best of my knowledge, from the causes stated.
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22a. SIGNATURE (Degree or title) L. Richard Webb, M.D.	22b. ADDRESS Springfield MO	22c. DATE SIGNED 6-27-59
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23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 6-27-1959	23c. NAME OF CEMETERY OR CREMATORY Oak Lawn	23d. LOCATION (City, town, or county) (State) Buffalo Mo
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24. FUNERAL DIRECTOR R B Jones	ADDRESS Buffalo Mo	25. DATE RECD. BY LOCAL REG. 6-29-59	26. REGISTRAR'S SIGNATURE Effie & Melton
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All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

JUL 2 1969

MAR 8 1960

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 *Leonard James*

Licensed Embalmer No. *2508*

P. O. Address. *Buffalo*

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.