

FILED VS SEP 15 1959 27

Registration District No. 27 Primary Registration District No. 4031 Registrar's No. 109

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <b>Bates</b>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Bates</b>		
b. CITY (If outside corporate limits, give TOWNSHIP only) <b>Adrian</b>		Length of stay in 1b <b>10 years</b>	c. CITY OR TOWN <b>Adrian</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location)		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>Joseph</b> Middle <b>Earl</b> Last <b>Rabourn</b>			4. DATE OF DEATH Month <b>Sept.</b> Day <b>1</b> Year <b>1959</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>10-21-92</b>	9. AGE (last birthday) <b>66</b>	IF UNDER 1 YEAR Months _____ Days _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <b>Bates County, Mo.</b>	12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>	
13a. FATHER'S NAME <b>Joseph Rabourn</b>		13b. MOTHER'S MAIDEN NAME <b>Josephine Morehouse</b>		14. NAME OF HUSBAND OR WIFE <b>Laura Rabourn</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>497-36-4435</b>	17. INFORMANT <b>Mrs. Laura Rabourn, Adrian, Mo.</b> Address _____		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma Lung</b> DUE TO (b) <b>metastatic Carcinoma</b> DUE TO (c) <b>Apine</b> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.					INTERVAL BETWEEN ONSET AND DEATH <b>2 years</b> <b>1 year</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)				PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
19. WAS AUTOPSY PERFORMED? 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.)			
20c. TIME OF INJURY Hour _____ a.m. _____ p.m. Month, Day, Year _____					
20d. INJURY OCCURRED 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>May 1959</b> to <b>Sept 1, 1959</b> and last saw him alive on <b>Aug 20, 1959</b> Death occurred at <b>4:33 P.M.</b> on the date stated above, and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) <b>Walter H. Butler MD</b>			22b. ADDRESS <b>Butler, Mo</b>		22c. DATE SIGNED <b>9/2/59</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>9-3-1959</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Scott Cemetery</b>	23d. LOCATION (City, town, or county) <b>Amsterdam Mo.</b>	(State)	
24. FUNERAL DIRECTOR <b>Six Funeral Service, Adrian, Mo.</b> ADDRESS _____		25. DATE RECD. BY LOCAL REG. <b>Sept. 3-1959</b>	26. REGISTRAR'S SIGNATURE <b>Wendall Kurray</b>		

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by \_\_\_\_\_ or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_ working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed \_\_\_\_\_ *Adrian*

Licensed Embalmer No. 3650

P. O. Address Adrian, 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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.

• If this body is not embalmed, fact should be so stated above.