

UNIVERSITY DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

'59 0 4 6 5 1 5

FILED VS DEC 16 1959

Registration District No. 333 Primary Registration District No. 3074 Registrar's No. 224 STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <u>SCOTT</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MISSOURI</u> b. COUNTY <u>STODDARD</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>SIKESTOWN</u>		c. CITY OR TOWN <u>RT #1 BELL CITY</u>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>DELTA COMMUNITY HOSP.</u>		d. STREET ADDRESS (If outside, give location) <u>BELL CITY, MISSOURI</u>	

3. NAME OF DECEASED (Type or print) First Middle Last <u>JENNIE BECK RAINEY</u>			4. DATE OF DEATH Month Day Year <u>NOVEMBER 30 1959</u>		
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>10-23-1923</u>	9. AGE (last birthday) <u>76</u>	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>HOUSEHOLD</u>	11. BIRTHPLACE (City and state or country) <u>KENTUCKY</u>	12. CITIZEN OF WHAT COUNTRY <u>U.S.</u>	
13a. FATHER'S NAME <u>ROBERT BECK</u>		13b. MOTHER'S MAIDEN NAME <u>BELLE JACKSON</u>		14. NAME OF HUSBAND OR WIFE <u>JAMES CLAUDE RAINEY</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>488-46-0365</u>	17. INFORMANT Address <u>EARL RAINEY BELL CITY, MO.</u>		

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:			INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u>			<u>1 day</u>
DUE TO (b) <u>Ventricular Fibrillation</u>			<u>1 day</u>
DUE TO (c) <u>Arteriosclerotic Heart Disease</u>			<u>years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Acute Cholecystitis severe, prostatic</u>			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 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 II if of item 18.) <u>Empyema of gall bladder 1 week</u>
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 checked="" 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 11-22-59 to 11-30-59 and last saw her alive on 11-30-59
Death occurred at 5:40 AM on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Begin or title) <u>Stephen Park M.D.</u>	22b. ADDRESS <u>Bloomfield, Mo.</u>	22c. DATE SIGNED <u>12-3-59</u>
23a. BURIAL, CREMATION, OR REMOVAL (Specify)	23b. DATE <u>12-2-59</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Morgan Mem. Park</u>
24. FUNERAL DIRECTOR ADDRESS <u>Wm H Morgan Advance, Mo.</u>		23d. LOCATION (City, town, or county) (State) <u>Advance, Mo.</u>

25. DATE RECD. BY LOCAL REG. <u>12-7-59</u>	26. REGISTRAR'S SIGNATURE <u>Mrs. Edna Hunter</u>
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(Licensed Embalmer's Statement on Reverse Side)

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 Wm H Morgan
Licensed Embalmer No. 4640

P. O. Address Advance,

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to conform 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.