

**IRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH**

**-60-016486**

**FILED VS MAY 16 1960**

Registration District No. 94 Primary Registration District No. 4449 Registrar's No. 60

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <u>Reginalde</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Reginalde</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Ellington</u>	Length of stay in 1b <u>LIFE</u>	c. CITY OR TOWN <u>Ellington</u>	Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Own Home</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u></u>

3. NAME OF DECEASED (Type or print) First <u>Stella</u> Middle <u>Flores</u> Last <u>Rains</u>			4. DATE OF DEATH Month <u>MAY</u> Day <u>3</u> Year <u>1960</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>2-2-1902</u>	9. AGE (last birthday) <u>58</u>	IF UNDER 1 YEAR Months <u>3</u> Days <u>1</u> Hours <u></u> Min. <u></u>	IF UNDER 24 HR Hours <u></u> Min. <u></u>
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></u>	11. BIRTHPLACE (City and state or country) <u>Reginalde County, Mo USA</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13a. FATHER'S NAME <u>Tom Nicholas</u>		13b. MOTHER'S MAIDEN NAME <u>Betty Melton</u>		14. NAME OF HUSBAND OR WIFE <u>Robert Rains</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>None</u>	17. INFORMANT Address <u>Robert Rains, Ellington 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 <u>5 yrs</u>	
IMMEDIATE CAUSE (a)	<u>CORONARY OCCLUSION</u>			
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b)	<u>DIABETES (MELLITUS)</u>		
	DUE TO (c)	<u>GEN. ARTERIOSCLEROSIS</u>		<u>10 yrs</u>
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 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.) <u></u>	
20c. TIME OF INJURY Hour <u></u> Month, Day, Year <u></u> s.m. <u></u> p.m. <u></u>	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.) <u></u>	20f. CITY, TOWN, OR LOCATION COUNTY STATE <u></u> <u></u> <u></u>
21. I attended the deceased from <u>1950</u> to <u>April 24</u> and last saw her/him alive on <u>April 26/60</u> Death occurred at <u>10:30 A.M.</u> m on the date stated above, and to the best of my knowledge, from the causes stated.			

22. SIGNATURE <u>Ernest Carter</u> (Degree or title) <u>MO</u>		22b. ADDRESS <u>Ellington, Mo</u>		22c. DATE SIGNED <u>5-5-60</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>5-6-60</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Red Ford</u>	23d. LOCATION (City, town, or county) (State) <u>Red Ford Mo</u>		
24. FUNERAL DIRECTOR <u>Ernest Carter</u> ADDRESS <u>Ellington</u>		25. DATE RECD. BY LOCAL REG. <u>MAY 5 1960</u>	26. REGISTRAR'S SIGNATURE <u>Edna Jannid</u>		

(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 me  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

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

Signed Chris L. Bennett

Licensed Embalmer No. 4574

P. O. Address Ellington

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.