

JRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-026011

XC-15176328 REC. NO. A2594

EMERALD VS AUG 1 2 1960

Primary Registration District No. **3007** Registrar's No. **456**

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY BUTLER				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MISSOURI b. COUNTY STODDARD									
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN POPLAR BLUFF		Length of stay in 1b 51 DAYS		c. CITY OR TOWN DEXTER		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>							
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION VETERANS ADMINISTRATION			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) 400 THOR AVENUE		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) First JESSE Middle DONALD Last GAINES				4. DATE OF DEATH Month JULY Day 29 Year 1960									
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 9-10-93		9. AGE (last birthday) 66		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HR	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FIREMAN				10b. KIND OF BUSINESS OR INDUSTRY FIREMAN		11. BIRTHPLACE (City and state or country) STODDARD COUNTY, MO.		12. CITIZEN OF WHAT COUNTRY U.S.A.					
13a. FATHER'S NAME FRANK GAINES				13b. MOTHER'S MAIDEN NAME ELLEN HILL				14. NAME OF HUSBAND OR WIFE HAZEL GAINES					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) YES WWI				16. SOCIAL SECURITY NO. UNKNOWN		17. INFORMANT Address HAZEL GAINES, DEXTER, MO. - WIFE							
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) UREMIA.										9/8 4 WEEKS			
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.) DUE TO (b) CHRONIC GLOMERULO-NEPHRITIS.										9/8 SEV. YEARS			
DUE TO (c)													
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"/> N- <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.)									
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					
VA		June 8, 1960		July 29, 1960		and last saw her/him alive on							
21. I attended the deceased from 12:20 AM on the date stated above, and to the best of my knowledge, from the causes stated.													
22a. SIGNATURE (Deceased or title) R. D. TURNER, M.D., Actg. Chief, Medical Svc. VA Hospital, Poplar Bluff, Mo.						22b. ADDRESS			22c. DATE SIGNED 8/2/60				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 8-1-60		23c. NAME OF CEMETERY OR CREMATORY Dexter			23d. LOCATION (City, town, or county) (State) Dexter Missouri						
24. FUNERAL DIRECTOR Strickland-Rainey Dexter, Mo.				25. DATE REC'D. BY LOCAL REG. 8/6/60		26. REGISTRAR'S SIGNATURE <i>[Signature]</i>							

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

MAY 23 1961

VS MAY 24 1961

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 Lucille Rainey

Licensed Embalmer No. 4983

P. O. Address Dexter

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.