

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

318

1003

4655-61-019387

STATE FILE NUMBER

AMENDED

Registration District No. Primary Registration District No. Registrar's No.

DATE AMENDED

INSTEAD OF

SHOULD READ

ITEM NO.

FILED JUN 2 1961
DOCUMENT
MEDICAL CERTIFICATION
BY AFFIDAVIT OF

1. PLACE OF DEATH
a. COUNTY

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Missouri b. COUNTY St. Louis

b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis Length of stay in 1b 3 days

c. CITY OR TOWN Northwoods Inside Limits Yes No

c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION De Paul Hospital Inside Limits Yes No

d. STREET ADDRESS (If outside, give location) 6619 Barken venue, 20, Reside on Farm Yes No

3. NAME OF DECEASED (Type or print) First Middle Last 4. DATE OF DEATH Month Day Year
JOHN H. RAINING May 15th, 1961

5. SEX Male 6. COLOR OR RACE White 7. Married Never Married Widowed Divorced 8. DATE OF BIRTH 5-18-1883 9. AGE (last birthday) 77 IF UNDER 1 YEAR Months Days Hours Min. IF UNDER 24 HR Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Meat Cutter 10b. KIND OF BUSINESS OR INDUSTRY Meat Market 11. BIRTHPLACE (City and state or country) St. Louis, Missouri 12. CITIZEN OF WHAT COUNTRY USA

13a. FATHER'S NAME William Raining 13b. MOTHER'S MAIDEN NAME Mary Lorch 14. NAME OF HUSBAND OR WIFE Gertrude Raining

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, give war or dates of service) No None 17. INFORMANT Address Gertude Raining, 6619 Barken Avenue, 20

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Arterio-sclerotic Heart Disease 2 yrs.
DUE TO (b) C-R-V Disease 3 months
DUE TO (c) Art-sclerosis - generalized

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (b) Atrial-fibrillation 4200 PART III. If deceased was female was there a pregnancy in last 90 days. Yes No Unknown

19. WAS AUTOPSY PERFORMED? YES NO 20a. ACCIDENT SUICIDE HOMICIDE 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)

20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.

20d. INJURY OCCURRED WHILE AT WORK NOT WHILE AT WORK 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 1959 to 5/15/61 and last saw her alive on 5/14/61 Death occurred at 5:30 A m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) William O. Mowley M.D. 22b. ADDRESS 231 Northwood Medical Bldg. 22c. DATE SIGNED 5/15/61

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial 23b. DATE 5-18-61 23c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery 23d. LOCATION (City, town, or county) St. Louis, Missouri (State)

24. FUNERAL DIRECTOR ADDRESS CALVIN F. FEUTZ, 4828 Natural Bridge Blvd., FUNERAL HOME, St. Louis, 15, Missouri. 25. DATE RECD. BY LOCAL REG. MAY 17 1961 26. REGISTRAR'S SIGNATURE Earl Smith, M.D.

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 Robert E. Muhlman

Licensed Embalmer No. 49/16

P. O. Address St Louis, 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.