N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 39318

Registration District No. 598 — Primary Registration District No. 4355-5 — Registrar's No. 37

1. PLACE OF DEATH:
(a) County: Morgan
(b) City or town: Moreau (If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: —
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution ____ (Specify whether years, months or days) In this community: Lifetime

2. USUAL RESIDENCE OF DECEASED:
(a) State: Missouri (b) County: Morgan
(c) City or town: Rural (If outside city or town limits, write "RURAL")
(d) Street No.: Moreau (If rural, give location)
(e) If foreign born, how long in U. S. A.? ____ years.

3. (a) PRINT FULL NAME: Bessie Merred Raines
3. (b) If veteran, name war: —
3. (c) Social Security No.: —
4. Sex: female
5. Color or race: White
6. (a) Single, widowed, married, divorced: Single
6. (b) Name of husband or wife: —
6. (c) Age of husband or wife if alive: ____ years
7. Birth date of deceased: Nov (Month) 7 (Day) 1924 (Year)

8. AGE: Years 15 | Months 9 | Days 15 | If less than one day ____ hr. ____ min.

9. Birthplace: Proctor (City, town, or county) Mo (State or foreign country)
10. Usual occupation: School
11. Industry or business: —
12. Name (FATHER): Charles E. Raines
13. Birthplace (FATHER): Proctor (City, town, or county) Mo (State or foreign country)
14. Maiden name (MOTHER): Olive Waisner
15. Birthplace (MOTHER): Nobby (City, town, or county) Mo (State or foreign country)
16. (a) Informant's own signature: Charles E. Raines
(b) Address: ____
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: Aug 23-40 (Month) (Day) (Year)
(c) Place: burial or cremation: Versailles City Cem
18. (a) Signature of funeral director: W. F. Kidwell
(b) Address: Versailles Mo.
19. (a) 8/2/40 (Date received local registrar) (b) Will F. Berry Jr (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month August day 22 year 1940 hour 8:10 minute A. M.
21. I hereby certify that I attended the deceased from Aug 19, 1940 to Aug 22 1940 that I last saw her alive on Aug 22 1940 and that death occurred on the date and hour stated above.

Immediate cause of death: peritonitis — Duration 48 hrs
Due to: unknown except possible attempt abortion
Due to: ____
Other conditions (Include pregnancy within 3 months of death): pregnant 4 mos.
Major findings: Of operations: — Of autopsy: —

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify): —
(b) Date of occurrence: —
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? (Specify type of place)
While at work? ____ (e) Means of injury: ____

23. Signature: A. J. Gunn (M. D. or other)
Address: Versailles Mo Date signed: 8-22-40

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 7,
District File Number 12-40-1663
Date Filed 12-3-40

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 Gene Bartram, Registered Apprentice No. ..... working under my personal supervision.

Signed Gene Bartram

Licensed Embalmer No. 4021

P. O. Address Versailles, M

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply wi the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.