S. No. 2
M—1/47
r. 5-17-39

FEDERAL SECURITY AGENCY
National Office of Vital Statistics

FILED AUG 13 1947

MISSOURI DIVISION OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 24337

Registration District No. 197

Primary Registration District No. 1002

Registrar's No. 3151

1. PLACE OF DEATH:
(a) County JACKSON
(b) City or town KANSAS CITY
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: VINEYARD PARK HOSPITAL
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 6 DAYS (Specify whether
In this community 9 YEARS years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MISSOURI (b) County JACKSON 48
(c) City or town KANSAS CITY 3
(If outside city or town limits, write "RURAL")
(d) Street No. 5644 SWOPE PARKWAY 8
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No) 0
If yes, name country --

3. (a) PRINT FULL NAME SAMUEL A. RAINS

3. (b) If veteran, name war No

3. (c) Social Security No. NONE

4. Sex MALE

5. Color or race WHITE

6. (a) Single, widowed, married, divorced WIDOWED

6. (b) Name of husband or wife MRS. MYRTLE RAINS

6. (c) Age of husband or wife if alive ..... years

7. Birth date of deceased FEBRUARY (Month) 18 (Day) 1860 (Year)

8. AGE:

Years	Months	Days	If less than one day
87	5	9	..... hr. ..... min.

9. Birthplace CARROLLTON (City, town, or county) ARKANSAS (State or foreign country)

10. Usual occupation FARMER

11. Industry or business

FATHER
12. Name JOHN RAINS
13. Birthplace TENNESSEE (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name ALLIE SPEAR
15. Birthplace ARKANSAS (City, town, or county) (State or foreign country)

16. (a) Informant Mrs J C Leyser
(b) Address 301 W Armour

17. (a) REMOVAL (Burial, cremation, or removal) (b) Date thereof JULY-27-1947 (Month) (Day) (Year)
(c) Place: burial or ~~cremation~~ ODD FELLOWS CEMETERY ALPENA PASS ARK.

18. (a) Signature of funeral director D. H. Newcomer's Sons
(b) Address 1401 BRUSH CREEK BLVD.

19. (a) 7-27-47 (Date received local registrar) (b) Geraldine Holmes (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month JULY day 27TH year 1947 hour 12 minute 30 A. M.

21. I hereby certify that I attended the deceased from July 1, 1947, to July 27, 1947 that I last saw him alive on July 26, 1947 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Cerebral thrombosis	2 days
Due to Arteriosclerosis	2 yrs.
Due to Senility	
Other conditions Polyposis of Colon (Include pregnancy within 3 months of death)	

Major findings:
Of operations None
Of autopsy 83 b

PHYSICIAN
Underline the cause of 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 0

23. Signature J. G. Sheldon (M. D. ~~number~~)
Address 922 Walnut Date signed 7-27-47
Kc. Mo.

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

Jefferson City Printing Co. (Licensed Embalmer's Statement on Reverse Side)

Vineyard Park Hospital

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 _____ _____, Registered Apprentice No. _____, working under my personal supervision.

Signed D. P. Nofsinger

Licensed Embalmer No. 3938

P. O. Address Kansas City 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 this body is not embalmed, fact should be so stated above.