

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. _____

FILED FEB 14 1949

No. 300
10. 48

BIRTH NO. _____ REG. DIST. NO. 274 PRIMARY REG. DIST. NO. 3052 Registrar's No. 42

1. PLACE OF DEATH a. COUNTY <u>PETTIS</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>MISSOURI</u> b. COUNTY <u>PETTIS MO</u>	
b. CITY OR TOWN <u>SEDALIA MO</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>SEDALIA, MO</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>BOTHWELL HOSPITAL</u>		d. STREET ADDRESS (If rural, give location) <u>1212 So. LAMINE</u>	
3. NAME OF DECEASED a. (First) <u>GEORGE</u> b. (Middle) <u>ARTHUR</u> c. (Last) <u>RABOURN</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>FEB. 1 1949</u>
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>MARRIED</u>	8. DATE OF BIRTH <u>MAY 16, 1879</u>
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FOREMAN, MO. PUB. SERV.</u>		9b. KIND OF BUSINESS OR INDUSTRY <u>GAS & LIGHT</u>	9. AGE (In years Last birthday) <u>69</u> IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
10a. FATHER'S NAME <u>WILLIAM Rabourn</u>		10b. MOTHER'S MAIDEN NAME <u>AMANDA MILLER</u>	11. BIRTHPLACE (State or foreign country) <u>LAMONTE, MISSOURI</u>
13a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		13b. SOCIAL SECURITY NO. <u>491-07-4506</u>	12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>
14. NAME OF HUSBAND OR WIFE <u>BESSIE Rabourne</u>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Mrs. Jessie Rabourn 1212 Lamine</u>	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Coronary Embolism.</u> ANTECEDENT CAUSES *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death. DUE TO (b) <u>First and Second Degree Burns, Both Legs, Buttocks and Scrotum.</u> DUE TO (c) <u>Chronic Myocarditis.</u> II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			INTERVAL BETWEEN ONSET AND DEATH <u>Dec. 29th 1948. Over one Year</u>
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION <u>None.</u>		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> <u>No.</u>
21a. ACCIDENT SUICIDE HOMICIDE (Specify) <u>Yes. See other side.</u>	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>See other side.</u>	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) <u>1212 South Lamine Street, Sedalia, Mo. 132</u>	
21d. TIME OF INJURY (Month) (Day) (Hour) (Minute) <u>December 29th, 1948. 12.30 P.M.</u>	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? <u>See other side.</u>	
22. I hereby certify that I attended the deceased from <u>December 29th 1948</u> , 19____, that I last saw the deceased alive on <u>January 20th, 1949</u> and that death occurred at <u>7.40 AM, February 1st, 1949</u> , stated above.			
23a. SIGNATURE <u>Jno. B. Carlisle, M.D.</u> (Degree or title)		23b. ADDRESS <u>Sedalia, Missouri.</u>	23c. DATE SIGNED <u>2-2-49</u>
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	24b. DATE <u>3 FEB. 1949</u>	24c. NAME OF CEMETERY OR CREMATORY <u>CROWN HILL CEMETERY</u>	24d. LOCATION (City, town, or county) (State) <u>SEDALIA MO.</u>
DATE REC'D BY LOCAL REG. <u>2-3-49</u>	REGISTRAR'S SIGNATURE <u>Betty Yeager Deputy</u>	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>W. Heckart, Sedalia, Mo.</u>	

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

This man came in from his work on December 29th, 1948. It was cold that day and he was cold from working outside. He backed up to a radiant gas heater to warm his legs. That is the back of his legs. In some way unknown his trousers caught fire and he sustained the described burns.

RECEIVED

Geo B. Carlisle M.D.
2-2-49

District Health Officer No. 8,

District File Number _____

Date Filed 2-11-49

AUG 31 1949

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.

Signed _____
Student Embalmer

Signed *Frank S. Coffman Jr*

Licensed Embalmer No. 4559

P. O. Address Sedalia, 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.