FILED MAR 30 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 9397

BIRTH NO. _____ REG. DIST. NO. 258 PRIMARY REG. DIST. NO. 4390 Registrar's No. 3

1. PLACE OF DEATH
a. COUNTY: OSAGE
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Meta
c. LENGTH OF STAY (In this place): 73 yrs
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location):

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Mo.
b. COUNTY: Osage
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Meta
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print)
a. (First): HENRY
b. (Middle): J.
c. (Last): RAILES

4. DATE OF DEATH (Month) (Day) (Year): March 16 1949

5. SEX: MALE
6. COLOR OR RACE: WHITE
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): MARRIED
8. DATE OF BIRTH: Oct. 4 1875
9. AGE (In years last birthday): 73 — If under 1 year: Months 5, Days 12 — If under 24 hrs.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Mo.
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13a. FATHER'S NAME: JOHN G. RAILES
13b. MOTHER'S MAIDEN NAME: MARGARET GREY
14. NAME OF HUSBAND OR WIFE: MINNIE RAILES

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO. (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT'S SIGNATURE OR NAME: CARL RAILES — ADDRESS: META, MO.

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Left Ventricular Failure. — INTERVAL BETWEEN ONSET AND DEATH: 2 days

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Cerebral Apoplexy. — 3 months
DUE TO (c) 22.11 X

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Arteriosclerosis. — 10 years

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?:

22. *I hereby certify that I attended the deceased from* Nov. *, 19* 48*, to* March 16 *19* 49*, that I last saw the deceased alive on* March 16*, 19* 49*, and that death occurred at* 1:00 P. *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): S. W. Gaston. D.O.
23b. ADDRESS: Meta Mo.
23c. DATE SIGNED: 3-17-49

24a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
24b. DATE: MARCH 18-49
24c. NAME OF CEMETERY OR CREMATORY: SOUTHSIDE
24d. LOCATION (City, town, or county) (State): META, MO

DATE REC'D BY LOCAL REG.: 3-17-49
REGISTRAR'S SIGNATURE: Rose Rowan 236
25. FUNERAL DIRECTOR'S SIGNATURE: H H Strop — **ADDRESS**: Meta Mo
(Licensed Embalmer's Statement on Reverse Side)

H.S.

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

RECEIVED
District Health Officer No. 9,
District File Number
Date Filed 3-28-42

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 H H Strop

Signed .....
Student Embalmer

Licensed Embalmer No. 2924

P. O. Address Mela Mo

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

If this body is not embalmed, fact should be so stated above.