S. No. 300
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0900
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

FILED APR 11 1951

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 9706

BIRTH NO. 23775-50 REG. DIST. NO. 300 PRIMARY REG. DIST. NO. 4449 Registrar's No. 4

1. PLACE OF DEATH
a. COUNTY: Reynolds
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Ellington
c. LENGTH OF STAY (in this place): life
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: Reynolds
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Ellington 0900
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print)
a. (First): Barbara
b. (Middle):
c. (Last): Rains

4. DATE OF DEATH (Month) (Day) (Year): Jan. 3 51

5. SEX: fem.
6. COLOR OR RACE: W.
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): infant
8. DATE OF BIRTH: 6/6/50
9. AGE (In years last birthday): IF UNDER 1 YEAR Months: 6 Days: 3 IF UNDER 24 HRS. Hours: Min.:
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): infant
10b. KIND OF BUSINESS OR INDUSTRY: —
11. BIRTHPLACE (State or foreign country): Ellington Mo.
12. CITIZEN OF WHAT COUNTRY?: A.

13a. FATHER'S NAME: Ray A. Rains
13b. MOTHER'S MAIDEN NAME: Muriel Farris
14. NAME OF HUSBAND OR WIFE: infant

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

MEDICAL CERTIFICATION

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.

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Broncho pneumonia — INTERVAL BETWEEN ONSET AND DEATH: 1 week

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death. 491X

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 1/1, 1951, to 1/3, 1951, that I last saw the deceased alive on 1/3, 1951, and that death occurred at 8-15 P m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title): T. T. O'Dell M.D.
23b. ADDRESS: Ellington Mo
23c. DATE SIGNED: 1/5/51

24a. BURIAL, CREMATION, REMOVAL (Specify): Removal
24b. DATE: 1/4 51
24c. NAME OF CEMETERY OR CREMATORY: Charleston Mo
24d. LOCATION (City, town, or county) (State):

DATE REC'D BY LOCAL REG.: 2/15-51
REGISTRAR'S SIGNATURE: Essie Evans
FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS: Phil A. Leuckel Ellington Mo

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED

APR 9 1951

DISTRICT HEALTH OFFICE No. 6

File No.....

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 1-3-5

.....

working under my personal supervision.

Student Embalmer No.....

Signed Phil A. Teuchel

Signed.....
Student Embalmer

Licensed Embalmer No. 2936

P. O. Address Van Buren 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.