

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

16347

State File No.

FILED MAY 25 1951

BIRTH NO. _____		REG. DIST. NO. <u>140</u>		PRIMARY REG. DIST. NO. <u>5549</u>		Registrar's No. <u>48</u>	
1. PLACE OF DEATH a. COUNTY <u>Howard</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Howard</u>			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Rural Richmond Twp.</u>		c. LENGTH OF RESIDENCE (In this place) <u>30 yrs</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Rural Richmond Twp.</u> <u>0450</u>			
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>R. F. D. #2</u>				d. STREET ADDRESS (If rural, give location). <u>R. F. D. #2</u>			
3. NAME OF DECEASED (Type or Print) a. (First) <u>George</u>		b. (Middle) <u>Enoch</u>		c. (Last) <u>Railsback</u>		4. DATE OF DEATH (Month) <u>May</u> (Day) <u>17</u> (Year) <u>1951</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>Sept. 23, 1878</u>		9. AGE (In years last birthday) <u>72</u>	IF UNDER 1 YEAR Months <u>7</u> Days <u>24</u>	IF UNDER 24 HRS. Hours <u></u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Farm</u>		11. BIRTHPLACE (State or foreign country) <u>Howard Co. Missouri</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13a. FATHER'S NAME <u>David Hagen Railsback</u>			13b. MOTHER'S MAIDEN NAME <u>Cothinea Frances</u>		14. NAME OF HUSBAND OR WIFE <u>Genelle Howard</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Mrs George Railsback Fayette, Mo</u>				
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, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Cerebral hemorrhage</u> ANTECEDENT CAUSES <u>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.</u> DUE TO (b) <u>Hypertension</u> DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS <u>Conditions contributing to the death but not related to the disease or condition causing death.</u>				INTERVAL BETWEEN ONSET AND DEATH <u>3 wks</u> <u>Unknown</u>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION <u>331X</u>				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
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) (Min.)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>29 April, 1951</u> , to <u>17 May, 1951</u> , that I last saw the deceased alive on <u>14 May, 1951</u> , and that death occurred at <u>A</u> m., from the causes and on the date stated above.							
23a. SIGNATURE <u>Mrs. J. Shaw M.D.</u>				23b. ADDRESS <u>Fayette Mo.</u>		23c. DATE SIGNED <u>19 May 51</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>5/19/51</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Fayette City Cemetery</u>		24d. LOCATION (City, town, or county) (State) <u>Fayette, Mo</u>		
DATE REC'D BY LOCAL REG. <u>5-19-51</u>		REGISTRAR'S SIGNATURE <u>Mary E. Shell</u> <u>436</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph A. Carr</u>		ADDRESS <u>Fayette, Mo</u>	

(Licensed Embalmer's Statement on Reverse Side)

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

1450
1

RECEIVED 5-24-51
DISTRICT HEALTH OFFICE No. 3
District File Number _____
Date Filed 5-27-51

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 _____

working under my personal supervision.

Student Embalmer No.

Signed Ralph A. Carr

Licensed Embalmer No. 3340

Signed.....
Student Embalmer

P. O. Address Fayette 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.