

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

39238

State File No. ....

FILED DEC 10 1953

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 149 PRIMARY REG. DIST. NO. 1002 Registrar's No. 5512

|   |  |  |  |
|---|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Jackson</u>   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>a. STATE <u>Missouri</u> b. COUNTY <u>Jackson</u> |  |
| b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Kansas City</u> |  | c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Kansas City</u>  |  |
| d. FULL NAME OF HOSPITAL OR INSTITUTION <u>3817 Bales Avenue</u>                                |  | d. STREET ADDRESS (If rural, give location) <u>3817 Bales Avenue</u>   |  |

|   |  |   |   |  |  |
|---|--|---|---|--|--|
| 3. NAME OF DECEASED (Type or Print)<br>a. (First) <u>Edith</u> b. (Middle) <u>W.</u> c. (Last) <u>Rains</u> |  |   | 4. DATE OF DEATH (Month) (Day) (Year)<br><u>November 19, 1953</u> |  |  |
| 5. SEX <u>Female</u>  |  | 6. COLOR OR RACE <u>White</u>   |   | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)<br><u>Married</u> |  |
| 8. DATE OF BIRTH<br><u>MAR 18 1895</u>  |  | 9. AGE (In years last birthday) <u>58</u>   |   | IF UNDER 1 YEAR: Months _____ Days _____                                 |  |
| IF UNDER 24 HRS: Hours _____ Min. _____   |  | 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>HOUSEWIFE</u> |   | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>---</u>                          |  |
| 11. BIRTHPLACE (City and State or Foreign Country)<br><u>SPRINGFIELD MISSOURI</u>                           |  |   | 12. CITIZEN OF WHAT COUNTRY?<br><u>U.S.A.</u>                     |  |  |

|  |  |   |  |  |  |
|--|--|---|--|--|--|
| 13a. FATHER'S NAME<br><u>CHARLES C. WALKER</u> |  | 13b. MOTHER'S MAIDEN NAME<br><u>MARY ELLEN PILAND</u> |  | 14. NAME OF HUSBAND OR WIFE<br><u>Homer G. Rains</u> |  |
|--|--|---|--|--|--|

|   |  |  |  |  |  |
|---|--|--|--|--|--|
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br><u>No</u> |  | 16. SOCIAL SECURITY NO.<br><u>NONE</u> |  | 17. INFORMANT'S SIGNATURE OR NAME AND ADDRESS<br><u>Mr. Homer G. Rains - 3817 Bales Avenue</u> |  |
|---|--|--|--|--|--|

|   |  |   |  |  |  |  |  |
|---|--|---|--|--|--|--|--|
| 18. CAUSE OF DEATH<br>Enter only one cause per line for (a), (b), and (c)<br><br>*This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death. |  | I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Polychemia Vera</u>   |  |  |  | INTERVAL BETWEEN ONSET AND DEATH<br><u>5 wks</u> |  |
|   |  | ANTECEDENT CAUSES<br>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.<br>DUE TO (b) _____<br>DUE TO (c) _____ |  |  |  |  |  |
|   |  | II. OTHER SIGNIFICANT CONDITIONS<br>Conditions contributing to the death but not related to the disease or condition causing death.                           |  |  |  | <u>294X</u>                                      |  |

|                        |  |                                  |  |  |  |   |  |
|------------------------|--|----------------------------------|--|--|--|---|--|
| 19a. DATE OF OPERATION |  | 19b. MAJOR FINDINGS OF OPERATION |  |  |  | 20. AUTOPSY?<br>YES <input checked="" 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 Oct 14 1953, to Nov 19 53, that I last saw the deceased alive on Nov 18 1953, and that death occurred at 10 P. M., from the causes and on the date stated above.

|   |  |  |  |  |  |
|---|--|--|--|--|--|
| 23a. SIGNATURE (Print name, degree or title)<br><u>Edith W. Rains</u> |  | 23b. ADDRESS<br><u>2004 Bryant, Blyden</u> |  | 23c. DATE SIGNED<br><u>Nov 20 1953</u> |  |
|---|--|--|--|--|--|

|  |  |                                 |  |  |  |  |  |
|--|--|---------------------------------|--|--|--|--|--|
| 24a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>BURIAL</u> |  | 24b. DATE<br><u>Nov 23 1953</u> |  | 24c. NAME OF CEMETERY OR CREMATORY<br><u>Mt. Moriah Cemetery</u> |  | 24d. LOCATION (City, town, or county) (State)<br><u>KANSAS CITY MISSOURI</u> |  |
|--|--|---------------------------------|--|--|--|--|--|

|   |  |   |  |   |  |   |  |
|---|--|---|--|---|--|---|--|
| DATE REC'D BY LOCAL REG.<br><u>11-21-53</u> |  | REGISTRAR'S SIGNATURE<br><u>Geraldine Smith</u> |  | 25. FUNERAL DIRECTOR'S SIGNATURE<br><u>W. H. Neocomer</u> |  | ADDRESS<br><u>1331 BROWN CREEK KANSAS CITY, MO.</u> |  |
|---|--|---|--|---|--|---|--|

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

*Handwritten signature or scribble*

**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.

Student .....  
Student Embalmer

Signed Clare V. Carr, Jr.

Licensed Embalmer No. 4934

P. O. Address R.C. 10, 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.