Health, & Welfare . Public h Service

S. 300 O
v. 1-56

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

FILED APR 17 1957

THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

13810

STATE FILE NUMBER

Registration District No. 383 Primary Registration District No. 5655 Registrar's No. 42

1. PLACE OF DEATH
a. COUNTY Lawrence
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Mt. Vernon — Inside Limits Yes ☐ No ☒
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location) Mo. State Sanatorium — Length of stay in lb 35 days

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Missouri b. COUNTY McDonald
c. CITY OR TOWN Goodman 0600 0 — Inside Limits Yes ☐ No ☐
d. STREET ADDRESS - Route 1 (If outside, give location) — Reside on Farm Yes ☐ No ☐

3. NAME OF DECEASED (Type or print) First Milo Middle D. Last Raines

4. DATE OF DEATH Month April Day 12 Year 1957

5. SEX Male O

6. COLOR OR RACE White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH March 22, 1896

9. AGE (In years last birthday) 61 — 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) Farmer

10b. KIND OF BUSINESS OR INDUSTRY Farming

11. BIRTHPLACE (City and state or country) Seligman, Mo. O

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME John Raines

14. MOTHER'S MAIDEN NAME unknown

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. none

17. INFORMANT Address San. records, Mo. State San., Mt. Vernon, Mo.

MEDICAL CERTIFICATION

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

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Bronchogenic carcinoma, left lung — INTERVAL BETWEEN ONSET AND DEATH 4 mo.

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b)

DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 162x

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒ 2

20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year

20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

20f. CITY, TOWN, OR LOCATION COUNTY STATE

21. I attended the deceased from 3-8-57, to 4-12-57 and last saw ~~her~~ him alive on 4-11-57
Death occurred at 1: 20 a.m. m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) C E Hellweg M.D. O

22b. ADDRESS Mt. Vernon, Mo.

22c. DATE SIGNED 4-12-57

23a. BURIAL, CREMATION, REMOVAL (Specify) Removal

23b. DATE 4-12-57

23c. NAME OF CEMETERY OR CREMATORY

23d. LOCATION (City, town, or county) Goodman (State) Mo.

24. FUNERAL DIRECTOR Max L Fossett ADDRESS Mt Vernon Mo.

25. DATE RECD. BY LOCAL REG. 4-12-57

26. REGISTRAR'S SIGNATURE Cecil Hendricks

(Licensed Embalmer's Statement on Reverse Side)

411-0

APR 18 1957

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was emba

by me, or by ....., Student Embalmer No.....

working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed Max L Fossett

Licensed Embalmer No. 425

P. O. Address McNeiver

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

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

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