

FILED OCT 16 1957

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

36078

STATE FILE NUMBER

4496

Registration District No. 149 Primary Registration District No. 1002

Registrar's No.

S. 300  
1-57

1. PLACE OF DEATH a. COUNTY <b>Jackson</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Kansas</b> b. COUNTY <b>Johnson</b>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Kansas City</b>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>Mission</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Research Hosp.</b>			Length of stay in lb <b>4 Weeks</b>		d. STREET ADDRESS <b>5608 Outlook</b>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>RUEL</b> Middle <b>HARRY</b> Last <b>RAINS</b>				4. DATE OF DEATH Month <b>Sept.</b> Day <b>25,</b> Year <b>1957</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>April 19, 1886</b>		9. AGE (In years last birthday) <b>71</b>	IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Partner-J.H. Mace Co.</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Jewelry</b>		11. BIRTHPLACE (City and state or country) <b>Moline, Illinois</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13a. FATHER'S NAME <b>Harry Rains</b>			13b. MOTHER'S MAIDEN NAME <b>Lillian Vandevere</b>			14. NAME OF <del>DECEASED'S</del> WIFE <b>Vivian Rains</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>			16. SOCIAL SECURITY NO. <b>495-05-0436</b>		17. INFORMANT Address <b>Mrs. Vivian Rains, Mission, Kansas.</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Myocardial Infarction</b>						INTERVAL BETWEEN ONSET AND DEATH <b>1 mo</b>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>Arteriosclerotic Heart Dis.</b>						<b>2 1/2 yrs</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) <b>4200</b>							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)				
20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.							
20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		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 <b>Apr 14, '54</b> to <b>Sept 25, '57</b> and last saw him alive on <b>Sept 25, '57</b> Death occurred at <b>3:50 P.M.</b> m on the date stated above; and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE <i>[Signature]</i> (Degree or title) <b>D</b>				22b. ADDRESS <b>778 D. Arvyle Bldg N.C. Mo</b>		22c. DATE SIGNED <b>9-27-57</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE	23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town, or county) (State)		
<b>Burial</b>		<b>Sept. 28, '57</b>	<b>Mt. Moriah Cemetery</b>		<b>Jackson County, Missouri</b>		
24. FUNERAL DIRECTOR <b>FREEMAN MORTUARY, Kansas City, Mo.</b>				25. DATE RECD. BY LOCAL REG. <b>9-27-57</b>	26. REGISTRAR'S SIGNATURE <i>[Signature]</i>		

I. C. Layton

MEDICAL CERTIFICATION

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.



*Dr. Lee C. Freeman  
Average 1300g - 1400g - 8227  
after 12.30 pm*

**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 .....  
Signature of Student Embalmer

Signed *J. C. Freeman* .....

Licensed Embalmer No. 2939  
P. O. Address F. C. M.

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.