

pt. Health,  
, & Welfare  
S. Public  
alth Service

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

45258

STATE FILE NUMBER

FILED JAN 6 1958

Registration District No. 272 Primary Registration District No. 1912 Registrar's No. 84

1. PLACE OF DEATH a. COUNTY <u>Comical</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Comical</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Steele</u> <u>WA</u>		c. CITY OR TOWN <u>Steele</u> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION		d. STREET ADDRESS (If outside, give location) <u>Route 3</u> Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First <u>Lillie</u> Middle <u>Raney</u> Last <u>Raney</u>			4. DATE OF DEATH Month <u>12</u> Day <u>1</u> Year <u>57</u>		
--	--	--	---	--	--

5. SEX <u>F</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10-12-1877</u>	9. AGE (In years last birthday) <u>80</u>	10. FUNDER YEAR Months <u>1</u> Days <u>19</u>	11. IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>
-----------------	-------------------------------	---	------------------------------------	---	---	--

10a. USUAL OCCUPATION (Give kind of work done during part of working life, even if retired) <u>Home work</u>	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <u>Wayne Co Tenn</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
---	-----------------------------------	--	--

13a. FATHER'S NAME <u>Bill Hatley</u>	13b. MOTHER'S MAIDEN NAME <u>Docie Steelhead</u>	14. NAME OF HUSBAND OR WIFE
--	---	-----------------------------

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.	17. INFORMANT <u>Mrs. Clarence Woods</u> Address <u>Steele Mo Rts</u>
--	-------------------------	--

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>myocardial infarction</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 or 3 yrs</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>thrombosis left leg</u>		
DUE TO (c) <u>arteriosclerosis</u>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>4221</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" 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 <u>  </u> Month, Day, Year a.m. <u>  </u> p.m. <u>  </u>	20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE WORK <input type="checkbox"/> 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 <u>1</u>	COUNTY	STATE
---	---	--	--	--------	-------

21. I attended the deceased from <u>7-1-57</u> to <u>12-1-57</u> and last saw her/him alive on <u>12-1-57</u> Death occurred at <u>  </u> m on the date stated above; and to the best of my knowledge, from the causes stated.	
---	--

22a. SIGNATURE <u>H. Melvin</u> (Degree or title)	22b. ADDRESS <u>Steele Mo</u>	22c. DATE SIGNED <u>12-13-57</u>
--	----------------------------------	-------------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE <u>12-3-57</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Dog Wood</u>	23d. LOCATION (City, town, or county) (State) <u>Blitzville Ark</u>
---	-----------------------------	---	--

24. FUNERAL DIRECTOR <u>Norman Eugene Steele</u> ADDRESS <u>Mo</u>	25. DATE RECD. BY LOCAL REG. <u>12/25-57</u>	26. REGISTERING SIGNATURE <u>L. J. Johnson</u>
---	---	---

(Licensed Embalmer's Statement on Reverse Side)

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.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

249-

1-5-55-24

JAN 3 - 1958

PEMISCOT COUNTY HEALTH DEPARTMENT  
COURTHOUSE PHONE 79  
CARUTHERSVILLE, MO.

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 *[Handwritten Signature]* .....

Licensed Embalmer No. *4732* .....  
P. O. Address *Stale, 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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.