

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

17352
STATE FILE NUMBER
REGISTRATION DISTRICT No. 149 Primary Registration District No. 100 Registrar's No. 6118

FILED JAN 17 1958

V. S. 300
Rev. 1-57

1. PLACE OF DEATH a. COUNTY Jackson		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Jackson	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Kansas City		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN Kansas City Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Osteopathic Hosp.		Length of stay in lb 53 yrs	d. STREET ADDRESS 2131 E. 82nd St. (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) AMY BELLE RAINES			4. DATE OF DEATH Month 12 Day 23 Year 1957
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 15, 1868
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker		10b. KIND OF BUSINESS OR INDUSTRY Home	11. BIRTHPLACE (City and state or country) Shelbina, Missouri
13a. FATHER'S NAME Herikah Crewler		13b. MOTHER'S MAIDEN NAME Ellen Foreman	14. NAME OF HUSBAND OR WIFE Wm. H. Raines (Deceased)
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. None	17. INFORMANT Address Julian W. Raines, 2131 E. 82nd Street
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchial pneumonia Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) cardiac decompensation DUE TO (c) cerebral fistula			INTERVAL BETWEEN ONSET AND DEATH 24 hrs 24 hrs 153+ 3 wks.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH (If not related to the terminal disease condition given in PART I (a)) Fistula was the result of an apparent carcinoma			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 Month, Day, Year a.m. p.m.		20d. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
20e. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20f. CITY, TOWN, OR LOCATION COUNTY STATE	
21. I attended the deceased from 12-6-57 to 12-23-57 and last saw her alive on 12-22-57 Death occurred at 9:30 AM 12-23-57 m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE H. J. Anally D.O. (Degree or title)		22b. ADDRESS 926 E. 11th St. K.C. Mo.	22c. DATE SIGNED 12-23-57
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 12-26-57	23c. NAME OF CEMETERY OR CREMATORY Forest Hill	23d. LOCATION (City, town, or county) (State) Kansas City, Mo.
24. FUNERAL DIRECTOR Mellody-McGilley-Eylar Funeral Home Linwood-Woodland		25. DATE RECD. BY LOCAL REG. 12-24-57	26. REGISTRAR'S SIGNATURE Neva Marshall

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



Dr. Mc Anally
Metropolitan Hall
926 E. 11th

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 *Melvin Barton*.....

Licensed Embalmer No. *4903*
P. O. Address *KC 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.