

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-019219  
STATE FILE NUMBER

Registration District No. 274 Primary Registration District No. 3052 Registrar's No. 238  
MAY 26 1958

1. PLACE OF DEATH a. COUNTY <b>Pettis</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Pettis</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Sedalia</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>Sedalia</b>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Bothwell Hospital</b>		Length of stay in lb <b>23 days</b>	d. STREET ADDRESS (If outside, give location) <b>2704 Clinton Road</b>
			Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <b>JOHN</b> Middle <b>WILLIAM</b> Last <b>RAINES</b>			4. DATE OF DEATH Month <b>May</b> Day <b>22</b> Year <b>1958</b>	
---	--	--	---	--

5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>October 7, 1871</b>	9. AGE (In years last birthday) <b>86</b>	FUNDER 1 YEAR Months <b>0</b> Days <b>0</b>	IF UNDER 24 HRS. Hours <b>0</b> Min. <b>0</b>
-----------------------	----------------------------------	---	--	--	--	--

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer retired</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>Gen Agriculture</b>	11. BIRTHPLACE (City and state or country) <b>Pilot Grove, Missouri</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
--	---	--	---

13a. FATHER'S NAME <b>Allen Raines</b>	13b. MOTHER'S MAIDEN NAME <b>Marguerite Bales</b>	14. NAME OF HUSBAND OR WIFE <b>Malldonia Spry Raines</b>
---	--	---

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <b>No</b>	16. SOCIAL SECURITY NO. <b>None</b>	17. INFORMANT <b>Mrs. Marguerite Shepherd, Ft. Lauderdale, Florida</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>Streptococcal meningitis</b>		INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <b>Cerebrovascular accident</b>	
	DUE TO (c) <b>Generalized arteriosclerosis</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>331X</b>		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 <b>7:30 pm</b> Month <b>May</b> Day <b>22</b> Year <b>1958</b>	20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION <b>Sedalia</b>	COUNTY <b>Pettis</b>	STATE <b>Missouri</b>
--	--	--	--	-------------------------	--------------------------

21. I attended the deceased from <b>10 May 58</b> to <b>22 May 58</b> and last saw him live on <b>22 May 58</b> Death occurred at <b>7:30 pm</b> on the date stated above; and to the best of my knowledge, from the causes stated.	
22a. SIGNATURE <b>Carl D. [Signature]</b> (Degree or title)	22b. ADDRESS <b>1216 West 12th St Sedalia Mo</b>
DATE SIGNED <b>22 May 58</b>	

23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>5/24/58</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Malta Bend Cemetery</b>	23d. LOCATION (City, town, or county) (State) <b>Malta Bend, Missouri</b>
--	-----------------------------	--	--

24. FUNERAL DIRECTOR <b>Ernest [Signature]</b>	ADDRESS <b>Sedalia, Mo.</b>	25. DATE RECD. BY LOCAL REG. <b>May 3 1958</b>	26. REGISTRAR'S SIGNATURE <b>Frances Shelby</b>
---	--------------------------------	---	--

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

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 *P. E. Baker* .....

Licensed Embalmer No. *2419* .....

P. O. Address *Sedalia, 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.