59-009615

THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

STATE FILE NUMBER

FILED APR 8 1959 Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 1471

1. PLACE OF DEATH
a. COUNTY Jackson
b. CITY OR TOWN (If outside corporate limits, give TOWNSHIP only) Kansas City — Inside Limits Yes [X] No [ ]
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location) Gen. Hospital — Length of stay in 1b 3 Days

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Missouri b. COUNTY Jackson
c. CITY OR TOWN Kansas City — Inside Limits Yes [X] No [ ]
d. STREET ADDRESS (If outside, give location) 745 N Prospect — Reside on Farm Yes [ ] No [X]

3. NAME OF DECEASED (Type or print) First LYDIA Middle A. Last RAINS

4. DATE OF DEATH Month 3 Day 19 Year 59

5. SEX Female
6. COLOR OR RACE White
7. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]
8. DATE OF BIRTH —
9. AGE (In years last birthday) 57 — 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) Housewife
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (City and state or country) Kansas City, Mo.
12. CITIZEN OF WHAT COUNTRY? U S A

13a. FATHER'S NAME Burton Burdick
13b. MOTHER'S MAIDEN NAME Ida Corning
14. NAME OF HUSBAND OR WIFE Carl W. Rains

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 Carl W. Rains Address 745 N. Prospect

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) Perforated abdominal Viscus
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) cholecystitis c̄ Cholelithiasis
DUE TO (c)
INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) History of duodenal ulcer.

19. WAS AUTOPSY PERFORMED? YES [ ] NO [X] 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 3-18-59, to 3-19-59 and last saw her/him alive on 3-19-59
Death occurred at 6:15 p.m. on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) Abraham Gelperin M.D.
22b. ADDRESS Gen. Hospital
22c. DATE SIGNED 3.20.59

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial
23b. DATE Mar 22 1959
23c. NAME OF CEMETERY OR CREMATORY Pleasant Ridge Cemetery
23d. LOCATION (City, town, or county) Harrisonville (State) Mo.

24. FUNERAL DIRECTOR Tannenburgers ADDRESS Harrisonville Mo.
25. DATE RECD. BY LOCAL REG. 3-20-59
26. REGISTRAR'S SIGNATURE Neva Minshall

(Licensed Embalmer's Statement on Reverse Side)

All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

Abraham Gelperin M. D.

DEC 14 1959

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 Ernest Runnenburger

Licensed Embalmer No. 3368

P. O. Address Harrisonville

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.