

MURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS OCT 21 1959

59-037979

STATE FILE NUMBER

Registration District No. _____ Primary Registration District No. _____ Registrar's No. **2 9353**

UNRECORDED

1. PLACE OF DEATH		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
a. COUNTY		a. STATE Mo.	b. COUNTY
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		c. CITY OR TOWN St. Louis	Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
Length of stay in 1b 40 Yrs.		d. STREET ADDRESS (If outside, give location) 2307 Park Ave.	Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Incarnate Word Hosp.		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	

3. NAME OF DECEASED (Type or print)			4. DATE OF DEATH	
First IDA	Middle CATHERINE	Last RAINSFORD	Month October	Day 8,
		Year 1959		
5. SEX Female	6. COLOR OR RACE White	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 8/15/87	9. AGE (last birthday) 72
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	11. BIRTHPLACE (City and state or country) Arkansas	12. CITIZEN OF WHAT COUNTRY U.S.A.
13a. FATHER'S NAME William Bays		13b. MOTHER'S MAIDEN NAME Annie Blum		14. NAME OF HUSBAND OR WIFE George Rainsford
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. 549 18 5282	17. INFORMANT Address George Rainsford-2307 Park Ave.	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) respiratory failure		
DUE TO (b) cerebral metastases		6 wks
DUE TO (c) adenocarcinoma of rectum		
DUE TO (c) adenocarcinoma of rectum, 4 yrs		

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a): pt. had adenocarcinoma rectum removed in 1956 pt. had adenocarcinoma rectum removed 4/9/56	PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown
--	--

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.) 154x
20c. TIME OF INJURY Hour _____ a.m. _____ p.m. _____	20d. INJURY OCCURRED WHILE AT WORK <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 1956 to 1959 and last saw her/him alive on 10-8-59		Death occurred at 3:25 P.M. on the date stated above, and to the best of my knowledge, from the causes stated.	

22a. SIGNATURE Tracy O. Hawk (Degree or title) M.D.	22b. ADDRESS 16 Hampton Village	22c. DATE SIGNED 10-9-59
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE 10-12-1959	23c. NAME OF CEMETERY OR CREMATORY Sunset Cemetery
23d. LOCATION (City, town, or county) St. Louis County, Missouri	24. FUNERAL DIRECTOR 2301 Lafayette Ave. McLAUGHLIN'S, St. Louis 4, Missouri	
25. DATE RECD. BY LOCAL REG. 10-12-1959	26. REGISTRAR'S SIGNATURE Head Smith, M.D. m.g.B.	

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by _____
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed H. G. Farris

Licensed Embalmer No. 3384

P. O. Address H. Farris

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.