

**JURY DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH**

**=60-036477**  
STATE FILE NUMBER

FILED VS SEP 8 1960 318

1003

9177

INDEXED

Primary Registration District \_\_\_\_\_ Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH a. COUNTY			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>ST. LOUIS</b>			Length of stay in 1b <b>2 DAYS</b>		c. CITY OR TOWN <b>MISSOURI</b> COUNTY <b>ST. LOUIS</b>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>ST. JOHNS HOSPITAL'</b>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <b>6048 SUTHERLAND</b>
3. NAME OF DECEASED (Type or print) First Middle Last <b>JOHN WILSON RAINER</b>			4. DATE OF DEATH Month Day Year <b>SEPTEMBER 16, 1960</b>		
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>CAUCASIAN</b>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>4/18/1881</b>	9. AGE (last birthday) <b>79</b>	IF UNDER 1 YEAR IF UNDER 24 HR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>SALESMAN (RETIRED)</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>HOTEL EQUIPMENT</b>	11. BIRTHPLACE (City and state or country) <b>WATERLOO, ILLINOIS</b>	12. CITIZEN OF WHAT COUNTRY <b>USA</b>	
13a. FATHER'S NAME <b>WILLIAM RAINER</b>		13b. MOTHER'S MAIDEN NAME <b>LOUISE HORHINE</b>		14. NAME OF HUSBAND OR WIFE <b>LILY RAINER (NEE DREHER)</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)   (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>420-0</b>		17. INFORMANT Address <b>MRS. LILY RAINER, 6048 SUTHERLAND ST. LOUIS</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) <u>Acute Coronary Thrombosis,</u> DUE TO (b) <u>Recurrent</u> DUE TO (c) <u>Arteriosclerotic Heart Disease</u>					INTERVAL BETWEEN ONSET AND DEATH <u>18 mo.</u> <u>3 yrs.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)				PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input 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.)	
20c. TIME OF INJURY Hour a.m. p.m.	Month, Day, Year				
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 <u>Jan 8, 1956</u> to <u>Sept 16, 1960</u> and last saw her/him alive on <u>Sept 16, 1960</u> Death occurred at <u>12:00 NOON</u> m on the date stated above, and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) <u>John G Matthew MD</u>			22b. ADDRESS <u>3707 Watson Rd</u>		22c. DATE SIGNED <u>9-17-60</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>REMOVAL</b>	23b. DATE <b>9/19/1960</b>	23c. NAME OF CEMETERY OR CREMATORY <b>OAK GROVE MAUSOLEUM</b>		23d. LOCATION (City, town, or county) (State) <b>ST. LOUIS COUNTY, MISSOURI</b>	
24. FUNERAL DIRECTOR ADDRESS <b>HOFFMEISTER COLONIAL MORTUARY 6464 CHIPPEWA STREET, ST. LOUIS, MISSOURI</b>			25. DATE RECD. BY LOCAL REG. <b>SEP 17 1960</b>	26. REGISTRAR'S SIGNATURE <u>Lois Smith, M.D.</u>	

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 Bill C. Branson

Licensed Embalmer No. 4768

P. O. Address St Louis

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.