

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-025797

STATE FILE NUMBER

Registration District No. 167 Primary Registration District No. 4257 Registrar's No. 32

1. PLACE OF DEATH a. COUNTY <u>Johnson</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>Lafayette</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Holden</u>		c. CITY OR TOWN <u>Odessa</u>	
Length of stay in 1b <u>3 days</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Holden Community Hosp.</u>		d. STREET ADDRESS (if outside, give location) <u>108 So. First</u>	
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First <u>Lula</u> Middle <u>Lee</u> Last <u>Raynes</u>			4. DATE OF DEATH Month <u>July</u> Day <u>16</u> Year <u>1961</u>		
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5. SEX <u>Fe</u>	6. COLOR OR RACE <u>White</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>9/15/76</u>	9. AGE (last birthday) <u>84</u>	IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	IF UNDER 24 HR Hours <u> </u> Min. <u> </u>
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>	10b. KIND OF BUSINESS OR INDUSTRY <u> </u>	11. BIRTHPLACE (City and state or country) <u>Bates City Mo.</u>	12. CITIZEN OF WHAT COUNTRY <u>U.S. A.</u>
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13a. FATHER'S NAME <u>Isaac Sims</u>	13b. MOTHER'S MAIDEN NAME <u>Katherine Kesterson</u>	14. NAME OF HUSBAND OR WIFE <u>Frank L. Raynes (deceased)</u>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO. <u> </u>	17. INFORMANT Address <u>Claude Raynes Pleasant Hill, Mo.</u>
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18. CAUSE OF DEATH (Enter only one cause here for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CEREBRAL VASCULAR ACCIDENT</u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>ARTERIOSCLEROSIS & HYPERTENSION</u>	
	DUE TO (c) <u> </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 checked="" type="checkbox"/> No <input type="checkbox"/> Unknown
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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.)
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20c. TIME OF INJURY Hour <u> </u> a.m. <u> </u> p.m. <u> </u> Month, Day, Year <u> </u>

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
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21. I attended the deceased from 7-13-61 to 7-16-61 and last saw her alive on 7-16-61
Death occurred at 8:10 PM on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <u>Ray Rivera, D.O.</u>	22b. ADDRESS <u>Odessa, Mo.</u>	22c. DATE SIGNED <u>7-18-61</u>
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23a. BURIAL, CREMATION, or other REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>7/19/61</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Strausburg Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>Strausburg Mo.</u>
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24. FUNERAL DIRECTOR <u>Husman Sparks</u>	ADDRESS <u>Odessa, Mo.</u>	25. DATE RECD. BY LOCAL REG. <u>7-18-61</u>	26. REGISTRAR'S SIGNATURE <u>Bernice Rose</u>
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DATE AMENDED

INSTEAD OF

DOCUMENT

MEDICAL CERTIFICATION

ITEM NO. SHOULD READ

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 me,
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed William T. Spa

Licensed Embalmer No. 4431

P. O. Address Odessa,

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.