Riverbay

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

92984

1 PLACE OF DEATH

County Greene

Township South Campbell Registration District No. 318 File No.

or

Village Primary Registration District No. 5440 Registered No. 747

or

City ~~Springfield Mo~~ (NO. 1600 W Phelps St.; Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME George Edward Rathbun.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 SINGLE MARRIED WIDOWED OR DIVORCED (Write the word): Single

6 DATE OF BIRTH: Oct. (Month) 6 (Day), 1901 (Year)

7 AGE: 7 yrs. 60 mos. 18 ds. If LESS than 1 day, ...hrs. or ....min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: At Home
(b) General nature of industry business, or establishment in which employed (or employer):

9 BIRTHPLACE (City or town, State or foreign country): Mo

PARENTS

10 NAME OF FATHER: Wm A. Rathbun

11 BIRTHPLACE OF FATHER (City or town, State or foreign country): Arkansas

12 MAIDEN NAME OF MOTHER: Isabelle Curlee

13 BIRTHPLACE OF MOTHER (City or town, State or foreign country): Ark

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) W. A. Rathbun

(Address) 1600 W Phelps

15 Filed OCT 23 1918 Edwin F. James Registrar
Dallie B Johnson Deputy Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: Oct (Month) 22nd (Day), 1918 (Year)

17 I HEREBY CERTIFY, that I attended deceased from Octob 12, 1918, to Octob 22nd, 1918, that I last saw him alive on Octob 22, 1918, and that death occurred, on the date stated above, at 3 p m.

The CAUSE OF DEATH* was as follows:

Broncho-Pneumonia

11 A

107 A

(Duration) ....yrs. ....mos. 6 ds.

CONTRIBUTORY (Secondary): Epidemic Influenza

(Duration) ....yrs. ....mos. 10 ds.

(Signed) D W Rienhoff M. D.

Octob 22, 1918 (Address) Lamb Hosp Springfield Mo

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL: Maple Park

DATE OF BURIAL: Oct 23, 1918

20 UNDERTAKER: Paxson Und Co

ADDRESS: 410 South St.

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

1 PLACE OF DEATH

County .....

Township ..... Registration District No. ..... File No. .....
or
Village ..... Primary Registration District No. ..... Registered No. .....
or
City ..... (NO. ....., ... St.: ..... Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME .....

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 SINGLE MARRIED WIDOWED OR DIVORCED (*Write* the word)

6 DATE OF BIRTH

..... (Month) ..... (Day), 1..... (Year)

7 AGE

.....yrs. .....mos. .....ds.

If LESS than 1 day, ...hrs. or .....min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work .....
(b) General nature of industry business or establishment in which employed (or employer) .....

9 BIRTHPLACE
(City or town, State or foreign country)

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER
(City or town, State or foreign country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER
(City or town, State or foreign country)

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) .....

(Address) .....

15

Filed ....., 191....., ...
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

..... (Month) ..... (Day), 191..... (Year)

17 I HEREBY CERTIFY, that I attended deceased from ....., 191....., to ....., 191.....,
that I last saw h.....alive on ....., 191.....,
and that death occurred, on the date stated above, at .....m.

The CAUSE OF DEATH* was as follows:

.....

.....

.....

..... (Duration) .....yrs. .....mos. .....ds.

CONTRIBUTORY .....
(Secondary)

..... (Duration) .....yrs. .....mos. .....ds.

(Signed) ..... M. D.

....., 191..... (Address) .....

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death .....yrs. .....mos. .....ds. In the State .....yrs. .....mos. .....ds.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL ....., 191.....
20 UNDERTAKER	ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

V. S. No. 2. A