

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

Do not use this space.

9680

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File No. _____
Registered No. 387
St. _____ Ward)

1. PLACE OF DEATH

County Richmond Registration District No. _____
Township _____ Primary Registration District No. 1001
City St Joseph (No. Mo. Mem. Hospital)

2. FULL NAME

Harnett Jane Rainforth
(a) Residence. No. _____ St. _____ Ward. Gravity, Iowa
(Usual place of abode) (If nonresident, give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 4 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F 4. COLOR OR RACE wh 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Francis Rainforth

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 7/3 - 1902

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
37 2 18

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer) _____
(c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Iowa

10. NAME OF FATHER Frank Fleming

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) Iowa

12. MAIDEN NAME OF MOTHER Mary E. Gorman

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) Illinois

14. INFORMANT (Address) Frank Fleming, Gravity, Iowa

15. FILED MAR 21 1929 John G. Wh REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Mar 21 1929

17. I HEREBY CERTIFY, That I attended deceased from Mar 19 1929 to Mar 21 1929 that I last saw her alive on Mar 21 1929, and that death occurred, on the date stated above, at Richmond m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Lobar Pneumonia
bilateral

(duration) yrs. mos. 5 ds.
CONTRIBUTORY (SECONDARY) 10/10 (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH _____

8 DID AN OPERATION PRECEDE DEATH. _____ -DATE OF: _____

9 WAS THERE AN AUTOPSY? _____

WHAT TEST CONFIRMED DIAGNOSIS

(Signed) H.S. Goyard M. D.

, 19 (Address) St Joseph Mo.

*State the DISEASE CAUSING DEATH, or deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) Whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Gravity Iowa DATE OF BURIAL 3/23 1929

20. UNDERTAKER J.R. Stinesley ADDRESS 216 So 10th

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

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