

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

Do not use this space.

10129

APR 24 1929

DEATH
County DeWitt Registration District No. 266
Township Spring Creek Primary Registration District No. 5-370
City Salmon Mo. (No. _____) St. _____ Ward _____

File No. _____
Registered No. XE
St. _____ Ward _____

2. FULL NAME John William Raybourn
(a) Residence No. _____ St. _____ Ward _____
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred 4 yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX male 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) widower
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF Matilda Raybourn (OR) WIFE OF _____
6. DATE OF BIRTH (MONTH, DAY AND YEAR) Sept 27 - 1866
7. AGE YEARS MONTHS DAYS IF LESS than 1 day, _____ hrs. or _____ min.
62 6 15

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

9. BIRTHPLACE (CITY OR TOWN) St Francis Mo.
(STATE OR COUNTRY)

10. NAME OF FATHER Thomas Raybourn

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

12. MAIDEN NAME OF MOTHER Eliza Ture

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) DeWitt Co Mo
(STATE OR COUNTRY)

14. INFORMANT Mrs Ed Sparks
(Address) Salmon Mo.

15. FILED 3/16 29 H. C. Knold, W.D.
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) March 15 1929
I HEREBY CERTIFY That I attended deceased from January 4 1929 to March 15 1929
that I last saw him alive on March 2 1929, and that death occurred, on the date stated above, at 2 2 m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Carcinoma of Stomach
arterio sclerosis and
arterial hypertension
(duration) 7 yrs. 5 mos. ds.
(SECONDARY) (duration) 1 yrs. 6 mos. ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH: _____

19. DID AN OPERATION PRECEDE DEATH? No DATE OF _____

20. WAS THERE AN AUTOPSY? No

WHAT TEST CONFIRMED DIAGNOSIS Final Physical
(Signed) Dr. G. Melville, M. D.
, 19 (Address) Salmon Mo.

*State the DISEASE CAUSING DEATH, or in 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 Minor Grave yard DATE OF BURIAL 3/17 1929

20. UNDERTAKER H. D. Hobson ADDRESS Salmon Mo.

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.

PARENTS

