

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

Do not use this space.

13913

1. PLACE OF DEATH
 County Buchanan Registration District No. 85
 Township St Joseph Primary Registration District No. 1001
 City St Joseph (No. Purpus Hospital)
 St. _____ Ward _____

2. FULL NAME Elvora Pearl Rainey
 (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 yrs. mos. da. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F **4. COLOR OR RACE** W **5. SINGLE, MARRIED, WIDOWED OR DIVORCED** (write the word) M

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF John R. Rainey

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Jan 23 1893

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, _____ hrs. or _____ min.

8. OCCUPATION OF DECEASED
 (a) Trade, profession, or particular kind of work Housework
 (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) Andrew Co Mo

10. NAME OF FATHER William Palmer

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

12. MAIDEN NAME OF MOTHER Elizabeth Brown

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

14. INFORMANT John R. Rainey
 (address) Mc Fall Mo

15. FILED 11 1929
John G. W. REGISTRAR

2 MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Apr 10 1929

17. I HEREBY CERTIFY, That I attended deceased from March 1929 to April 1929 that last saw _____ alive on _____ 1929, and that death occurred, on the date stated above, at _____ m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Meningitic (Traumatic)
1846
1929 (duration) yrs. mos. 17 da.
CONTRIBUTORY (SECONDARY) Fracture of skull
Basilar (duration) yrs. mos. ds.
18. WHERE WAS DISEASE CONTRACTED home
 IF NOT AT PLACE OF DEATH _____
DID AN OPERATION PRECEDE DEATH? No DATE OF _____
WAS THERE AN AUTOPSY? No

WHAT TEST CONFIRMED DIAGNOSIS ✓
 (Signed) J. S. Ferguson M. D.
4/12 1929 (Address) First Bldg St Joseph 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 Mc Fall Mo **DATE OF BURIAL** 4/12 1929

20. UNDERTAKER Heeman Funeral Home **ADDRESS** 1208 Francis

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.

WITH OUTFRADING INK—THIS IS A PERMANENT RECORD

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31

