

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

Do not use this space.

36968

**1. PLACE OF DEATH**

County Henry Registration District No. 347  
Township Clinton Primary Registration District No. 3018  
City Clinton (No. ....) St. .... (Ward) .....

File No. ....  
Registered No. 134

**2. FULL NAME**

Laura B Rainey  
(a) Residence No. 702 E Green 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. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX <u>F</u>	4. COLOR OR RACE <u>W</u>	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) <u>wid</u>
5A. IF MARRIED, WIDOWED OR DIVORCED HUSBAND OF (OR) WIFE OF <u>Joe L Rainey</u>		
6. DATE OF BIRTH (MONTH, DAY AND YEAR) <u>Dec 14 1879</u>		
7. AGE YEARS <u>56</u>	MONTHS <u>11</u>	DAYS <u>4</u>
8. OCCUPATION OF DECEASED (a) Trade, profession, or particular kind of work <u>House work</u> (b) General nature of industry, business, or establishment in which employed (or employer) .....		
9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Cedar Co</u>		
10. NAME OF FATHER <u>Joe Harvey</u>		
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) <u>Don't know</u>		
12. MAIDEN NAME OF MOTHER <u>.....</u>		
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) <u>.....</u>		
14. INFORMANT (Address) <u>Mrs. Leba Rainey</u>		
15. FILED <u>11/26 1929</u> <u>H. E. C. Beeler</u> REGISTRAR		

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) 11-18 1929

17. I HEREBY CERTIFY, That I attended deceased from 11-18 1929 to 11-18 1929  
that I last saw him alive on 11-18 1929, and that death occurred, on the date stated above, at 8 m.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:  
apoplexy  
92A  
MCAI  
(duration) ..... yrs. .... mos. .... ds.

CONTRIBUTORY (SECONDARY) MCAI  
(duration) ..... yrs. .... mos. .... ds.

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

19. DID AN OPERATION PRECEDE DEATH? ..... DATE OF .....

20. WAS THERE AN AUTOPSY? .....

WHAT TEST CONFIRMED DIAGNOSIS?  
(Signed) E. S. Walker, M. D.  
11-18 1929 (Address) Clinton 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 <u>Lebo Cem</u>	DATE OF BURIAL <u>11/19 1929</u>
20. UNDERTAKER <u>Spore &amp; Son</u>	ADDRESS <u>Clinton mo</u>

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.

