

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

Do not use this space.

20308

PLACE OF DEATH

County Pike Registration District No. 689
 Town Louisiana Primary Registration District No. 3033
 City Louisiana (No. Pike Co Hosp) St. _____ Ward _____

2. FULL NAME

Rayson
 (a) Residence No. 315 N 13 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 Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Single
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF _____
 6. DATE OF BIRTH (MONTH, DAY AND YEAR) 6/10/30
 7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or 5 min.

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

9. BIRTHPLACE (CITY OR TOWN) Louisiana
 (STATE OR COUNTRY) Mo

10. NAME OF FATHER Lynn Rayson
 11. BIRTHPLACE OF FATHER (CITY OR TOWN) _____
 (STATE OR COUNTRY) Louisiana Mo
 12. MAIDEN NAME OF MOTHER Hedyschneider
 13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Canton
 (STATE OR COUNTRY) Mo

14. INFORMANT Lynn Rayson
 (Address) Louisiana Mo

15. FILED 6/10/30 JCHaugh REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 6/10/30
 17. I HEREBY CERTIFY, That I attended deceased from 6/10/30 to 6/10/30
 that I last saw him alive on 6/10/30 and that death occurred, on the date stated above, at 11:30 a m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

6/1
 _____ (duration) _____ yrs. _____ mos. _____ ds.

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

18. WHERE WAS DISEASE CONTRACTED
 IF NOT AT PLACE OF DEATH _____
 DID AN OPERATION PRECEDE DEATH? no DATE OF _____
 WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS?
 (Signed) D M Pierson M. D.
6/10/30 (Address) Louisiana 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 Reverend Louisiana Mo DATE OF BURIAL 6/10/30

20. UNDERTAKER JCHaugh ADDRESS Louisiana Mo

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

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH

County Osage Registration District No. 689 File No. _____
 Township _____ Primary Registration District No. 3033 Registered No. _____
 City Louisiana (No. _____) St. _____ Ward _____

2. FULL NAME

Infant Bryson

(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. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

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

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) _____

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 _____
 (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) _____

10. NAME OF FATHER _____

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

12. MAIDEN NAME OF MOTHER _____

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

14. INFORMANT (Address) _____

15. FILED 6/10/30 J. Chapp REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) June 10 1930

17. I HEREBY CERTIFY That I attended deceased from _____, 19____, to _____, 19____, that I last saw h. _____ alive on _____, 19____, and that death occurred, on the date stated above, at _____.

THE CAUSE OF DEATH WAS AS FOLLOWS:

Small pox
 (duration) _____ yrs. _____ mos. _____ ds.

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

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

DID AN OPERATION PRECEDE DEATH? _____ DATE OF _____

WAS THERE AN AUTOPSY? _____

WHAT TEST CONFIRMED DIAGNOSIS? 6

(Signed) _____, M. D.
 _____, 19____ (Address)

*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 DATE OF BURIAL

20. UNDERTAKER ADDRESS

N. B.—Every item of information 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. REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

SUPPLEMENTARY

S-20306