

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

Do not use this space.

20584
~~20002~~

1. PLACE OF DEATH

County St. Louis Registration District No. 1160
Township Central Primary Registration District No. 4472
City University City mo. 6431^a Bates Ave

File No. _____
Registered No. 59
St. _____ Ward _____

2. FULL NAME

Rose Lawrence Rawlings
(a) Residence. No. 6431^a Bates Ave 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 female 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) widow

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Henry Clay Rawlings

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Aug 14 - 1892

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
57 10 11

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) Indiana

10. NAME OF FATHER Don't know

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) Don't know

12. MAIDEN NAME OF MOTHER Blanca Dietz

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) Don't know

14. INFORMANT Mrs. J. H. Rawlings
(Address) 6431^a Bates Ave

15. FILED 6/28, 19 30 Leva V. Maeller
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) June 25 1930

17. I HEREBY CERTIFY, That I attended deceased from Mar 19 1926 to June 25 1930, that I last saw him alive on June 21 1930, and that death occurred, on the date stated above, at _____ m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Chronic Myocarditis
93%
190 (duration) 4 yrs. mos. ds.

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

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF BIRTH _____

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

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS All symptoms
(Signed) J. O. Thurston, M. D.

(Address) 675³ Page

*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

Kansas City, Mo 6-29 1930
20. UNDERTAKER Geo. L. Pleitsch
ADDRESS 5966 Easton Ave

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

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