NOV 3 1930

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

Do not use this space.

31831

1. PLACE OF DEATH
County Scotland
Township Hudson
City Memphis (No. ..... St. ..... Ward)

Registration District No. 810
Primary Registration District No. 4488

File No. .....
Registered No. 58

2. FULL NAME Robert Wells Raines

(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	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write* the word)
male	white	single

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) May 16 1926

7. AGE YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
4	4	13	

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) Memphis
(STATE OR COUNTRY) Mo

PARENTS

10. NAME OF FATHER W. M. Raines
11. BIRTHPLACE OF FATHER (CITY OR TOWN) Memphis
(STATE OR COUNTRY) Mo
12. MAIDEN NAME OF MOTHER Gladys Wells
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) .....
(STATE OR COUNTRY) Scotland County Mo

14. INFORMANT W. M. Raines
(Address) Memphis Mo

15. FILED 10/4 1930 C. E. Parrish REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Sept 29 1930

17. I HEREBY CERTIFY, That I attended deceased from Oct 10- 1927 to 9-29- 1930 that I last saw him alive on 9-29- 1930 and that death occurred, on the date stated above, at 5.30 A. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Lymphiod leucemia 72 A

..... (duration) 2 yrs. ..... mos. ..... ds.

CONTRIBUTORY (SECONDARY) Cant Say

..... (duration) ..... yrs. ..... mos. ..... ds.

18. WHERE WAS DISEASE CONTRACTED 650

IF NOT AT PLACE OF DEATH .....

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

WAS THERE AN AUTOPSY? No

WHAT TEST CONFIRMED DIAGNOSIS? Laboratory

(Signed) C. E. Parrish, M. D.

10/4 1930 (Address) Memphis, 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	DATE OF BURIAL
Memphis cemetery	10/1 1930
20. UNDERTAKER W. H. Payne & Sons	ADDRESS Memphis

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.