

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

Do not use this space.

Dr. J. E. Raul
239073

1. PLACE OF DEATH

County *Greene Home* Registration District No. *318*
Township *Maple Grove* Primary Registration District No. *2001*
City *Maple Grove* (If nonresident give city or town and State) St. *Mo.* Ward *904*

2. FULL NAME

(a) Residence. No. *501 E. Canal* St. *Mo.* Ward *904*
(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. da.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *Male* 4. COLOR OR RACE *White* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) *Married*

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) *June 3-1860*

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min. *70, 5, 28*

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) *Spain*

10. NAME OF FATHER *McLaughly*

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

12. MAIDEN NAME OF MOTHER *McLaughly*

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

14. INFORMANT (Address) *Mrs. J. E. Raul Springfield Mo.*

15. FILED *123*, 19. *30* *J. E. Raul* REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) *Dec 1st 1930*

17. I HEREBY CERTIFY, That I attended deceased from *N.O.T.* *28th*, 19*30* to *Dec 1st*, 19*30*, and that I last saw him alive on *Dec 1st*, 19*30*, and that death occurred, on the date stated above, at *11:30 a* m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

11:30 Pneumonia (Bronchial)
(duration) yrs. mos. da.

CONTRIBUTORY (SECONDARY) *100%*
(duration) yrs. mos. da.

18. WHERE WAS DISEASE CONTRACTED *at home*
IF NOT AT PLACE OF DEATH? *✓*

DID AN OPERATION PRECEDE DEATH? *N.O.* DATE OF *✓*

WAS THERE AN AUTOPSY? *No*

WHAT TEST CONFIRMED DIAGNOSIS? *N.O.*

(Signed) *J. E. Raul*, M. D.
Dec 3rd 1930 (Address) *Springfield 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 *At home* DATE OF BURIAL *Dec 3 1930*

20. UNDERTAKER *H. W. Stowers* ADDRESS *Springfield*

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.

JAN 19 1931

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