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

Do not use this space.

File No. 7698

Registered No. 2069

1. PLACE OF DEATH

County ..... Registration District No. 791 ~~1003~~

Township ..... Primary Registration District No. ..... '

City St Louis Mo. (No. St Marys Infirmary St. ..... Ward)

2. FULL NAME John Gilbert Raines

(a) Residence. No. 717 Marion St., 23 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	infant

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Nov 16 1930

7. AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	2	29	

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) ..... (STATE OR COUNTRY) Missouri !

PARENTS

10. NAME OF FATHER John Raines

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

12. MAIDEN NAME OF MOTHER Effie Hoskins

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

14. INFORMANT Mr John Raines
(Address) 717 Marion

15. FILED Feb 16 1931 Ray C. Stadler REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Feb 15 1931

17. I HEREBY CERTIFY, That I attended deceased from 2/12/31, 19..., to 2/14/31, 19..., that I last saw ~~him~~ alive on 2/14/31, 19..., and that death occurred, on the date stated above, at 11:20 ~~P~~ a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

1 Bronchopneumonia
1 4
1 5 (duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (SECONDARY) Dehydration — (duration) ....yrs. ....mos. 4 ds.

18. WHERE WAS DISEASE CONTRACTED? 717 Marion
IF NOT AT PLACE OF DEATH
DID AN OPERATION PRECEDE DEATH? No DATE OF —
WAS THERE AN AUTOPSY? yes
WHAT TEST CONFIRMED DIAGNOSIS? X Ray etc.
(Signed) R. O. Smyth, M. D.
2/15, 1931 (Address) 1536 Papin

*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 St Matthews Cem. DATE OF BURIAL Feb 16 1931

20. UNDERTAKER E. J. Schmun ADDRESS 3125 Lafayette av

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.

WRITE PLAINLY. BOTH ONE PAGE AND

dehydration