REC'D MAR 14 1938

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

Do not use this space 5316

791

1. PLACE OF DEATH
(a) County ..... Registration District No. 1003
(b) Township ..... Primary Registration District No. ..... Registered No. 1961
(c) City St. Louis (d) Street No. City Hospital No.1 St.
(If death occurred in Hospital or Institution, write its name instead of street and number)
(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.
C. 17002

2. PRINT FULL NAME Joseph Raines 5 9.0
(a) Residence, No. 1304 St Ange St. 22
(Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

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) Aug 7 1915

7. AGE 22 YEARS MONTHS 6 DAYS 14 If LESS than 1 day, ... hrs. or ..... min.

OCCUPATION
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.
9. Industry or business in which work was done, as saw mill, bank, etc. nil
10. Date deceased last worked at this occupation (month and year)
11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Illinois

FATHER
13. NAME John Raines
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Illinois

MOTHER
15. MAIDEN NAME Effie Hoskins
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Illinois

17. INFORMANT (ADDRESS) Hosp. Info M.Kent

18. BURIAL, CREMATION, OR REMOVAL
PLACE St. Matthews DATE 2/24/38 19

19. FUNERAL DIRECTOR (ADDRESS) Allen W. McLaughlin 2301 Lafayette

20. FILED FEB 23 1938 19 J.F. Bredeck Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 2/21/38, 19

22. I HEREBY CERTIFY, That I attended deceased from 2/18/38 19 to 2/21/38, 19
I last saw him alive on 2/21/38, 19 Death is said to have occurred on the date stated above, at 9.05 a m.
The principal cause of death and related causes of importance were as follows:

Rheumatic heart disease - chronic - with aortic and mitral stenosis

Date of onset

Other contributory causes of importance:

Name of operation ..... Date of .....
What test confirmed diagnosis? ..... Was there an autopsy? No

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? ..... Date of injury ....., 19
Where did injury occur? ..... (Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place.
Manner of injury .....
Nature of injury .....

24. Was disease or injury in any way related to occupation of deceased? .....
If so, specify .....
(Signed) E. P. Rich, M. D.
(Address) City Hospital No.1

(Licensed Embalmer's Statement on Reverse Side)

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.

WHITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

I X12004

STATEMENT BY LICENSED EMBALMER

I, L. R. Cooper, Licensed Embalmer No. 3633

hereby certify that the body recorded on the reverse side of this certificate was embalmed by me

L. E.

No. or by Registered Apprentice No.

working under my personal supervision.

Signed L. R. Cooper

Licensed Embalmer No. 3633

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)