

JUN 26 1940

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

18611  
Do not use this space.

1. PLACE OF DEATH

(a) County FRAN Registration District No. 390  
(b) Township 91 Union Primary Registration District No. 5545 Registered No. 9  
(c) City ..... (d) Street No. .... 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.

2. PRINT FULL NAME

143 BERTHA TRAYFIELD  
(a) Residence, No. ANNAPOLIS MO St.  (If nonresident, give city or town and State)  
(Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX FEMALE 4. COLOR OR RACE WHITE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) MARRIED

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) May 2 1887

7. AGE YEARS 52 MONTHS 8 DAYS 6 IF LESS than 1 day, ..... hrs. or ..... min.

OCCUPATION 8. Trade, profession, or particular kind of work done, as a lawyer, bookkeeper, etc. 9. Industry or business in which work was done, as saw mill, bank, etc. HOUSE WIFE 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) ANNAPOLIS MO

FATHER 13. NAME JOHN SUTTON

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) ANNAPOLIS MO

MOTHER 15. MAIDEN NAME

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

17. INFORMANT (ADDRESS) JOHN TRAYFIELD

18. BURIAL, CREMATION, OR REMOVAL PLACE MINE CEMETERY DATE 2/9 1940

19. FUNERAL DIRECTOR (NAME) A. RUCKER FUNERAL SDR. (ADDRESS) IRONTON MO

20. FILED 6/8 1940 W. B. Hunter Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Feb 8 1940

22. I HEREBY CERTIFY, that I attended deceased from Jan 31 1940 to Feb 8 1940. I last saw him alive on Feb 6 1940. Death is said to have occurred on the date stated above, at 6:45 A m. The principal cause of death and related causes of importance were as follows:

Influenza  
Broncho-Pneumonia  
Date of onset 1/9/40

Name of operation ..... Date of .....  
What test confirmed diagnosis? ..... Was there an autopsy? .....

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? no  
If so, specify G. C. Anson M. D. (Signed) W. B. Hunter (Address) Ironton Mo

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.

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**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, .....

....., or by .....

Registered Apprentice No. ...., working under my personal supervision.

Signed

*Geo P Leuchel*

Licensed Embalmer No.

*3475*

P. O. Address

*Fronton Mo.*

**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.)**

**If this body is not embalmed, above space should be left blank.**

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 18611

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

Registration District No. 390

Primary Registration District No. 5845

Registrar's No.

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD  
SINA MOORE

1. PLACE OF DEATH  
 (a) County. St. Louis  
 (b) City or town. St. Louis  
 (If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution:  
 (If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution. \_\_\_\_\_ (Specify whether  
 In this community \_\_\_\_\_ years, months or days)

3. (a) PRINT FULL NAME Bertha Rayfield  
 3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex 7 5. Color or race W  
 6. (a) Single, widowed, married, divorced m  
 6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband, or wife, if alive \_\_\_\_\_ years

7. Birth date of deceased (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
52 9 6 hr. min.

9. Birthplace (City, town, or county) (State or foreign country)

10. Usual occupation

11. Industry or business

MOTHER FATHER { 12. Name

13. Birthplace (City, town, or county) (State or foreign country)

14. Maiden name Bertha Bullen  
 15. Birthplace Annapolis Md. Missouri (City, town, or county) (State or foreign country)

16. (a) Informant (b) Address

17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year) (c) Place: burial or cremation

18. (a) Signature of funeral director (b) Address

19. (a) (Date received local registrar) (b) B.C. Gunter (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:  
 (a) State \_\_\_\_\_ (b) County \_\_\_\_\_  
 (c) City or town \_\_\_\_\_ (If outside city or town limits write "RURAL")  
 (d) Street No. \_\_\_\_\_ (If rural, give location)  
 (e) If foreign born, how long in U. S. A. ? \_\_\_\_\_ years

MEDICAL CERTIFICATION  
 20. DATE OF DEATH Month 2 day 8 year \_\_\_\_\_ hour \_\_\_\_\_ minute \_\_\_\_\_ M.  
 21. I hereby certify that I attended the deceased from \_\_\_\_\_ 19\_\_\_\_, to \_\_\_\_\_ 19\_\_\_\_; that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_ 19\_\_\_\_ and that death occurred on the date and hour stated above.

Immediate cause of death \_\_\_\_\_  
 Due to \_\_\_\_\_  
 Due to \_\_\_\_\_  
 Other conditions (Include pregnancy within 3 months of death)  
 Major findings: Of operations \_\_\_\_\_  
 Of autopsy \_\_\_\_\_

Duration  
 PHYSICIAN  
 Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:  
 (a) Accident, suicide, or homicide (specify) \_\_\_\_\_  
 (b) Date of occurrence \_\_\_\_\_  
 (c) Where did injury occur? (City or town) (County) (State)  
 (d) Did injury occur in or about home, on farm, in industrial place, in public place?  
 While at work (Specify type of place) (c) Means of injury \_\_\_\_\_  
 23. Signature G.C. Quason (M. D. or other)  
 Address St. Louis Mo Date signed \_\_\_\_\_

SUPPLEMENTAL

