

No. 2
12-40
7-39
X23159

DEC 11 1940

Registration District No. 74

Primary Registration District No. 4042

Registrar's No. 18

1. PLACE OF DEATH: Boone
 (a) County Boone
 (b) City or town Hallsville
 (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) 2

2. USUAL RESIDENCE OF DECEASED:
 (a) State Missouri (b) County Boone
 (c) City or town Hallsville
 (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.

3. (a) PRINT FULL NAME Charles William Rawle
 3. (c) Social Security No. _____
 3. (b) If veteran, name war _____

MEDICAL CERTIFICATION
 20. DATE OF DEATH: Month Nov, day 29th
 year 1940 hour 11 minute 05⁹ M.

4. Sex Male 5. Color or race white
 6. (a) Single, widowed, married, divorced married
 6. (b) Name of husband or wife Luey Rawle
 6. (c) Age of husband or wife if alive 79 years
 7. Birth date of deceased March 11 1958
 (Month) (Day) (Year)

21. I hereby certify that I attended the deceased from 1937, 1937, to Nov. 29th 1940, 1940 that I last saw him alive on 11/29/40, 1940 and that death occurred on the date and hour stated above. 11:05 AM
 Duration _____

8. AGE: Years 92 Months 9 Days 18 If less than one day _____ hr. _____ min.

Immediate cause of death Chronic myocarditis
 Due to _____
 Due to _____ 930

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

Other conditions _____ (Include pregnancy within 3 months of death)
 Major findings: _____
 Of operations _____
 Of autopsy _____

10. Usual occupation Farmers and Stock Raiser
 11. Industry or business Retired

MOTHER FATHER
 12. Name Dr. Samuel Rawle
 13. Birthplace New York State
 (City, town, or county) (State or foreign country)
 14. Maiden name Elizabeth T. Summers
 15. Birthplace Randolph Co. Mo.
 (City, town, or county) (State or foreign country)

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

16. (a) Informant Mrs. Ed. McDonald
 (b) Address 606 South Fifth St. Osberly Mo.
 17. (a) Burial (b) Date thereof Dec. 1 1940
 (Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation Centralia Cemetery

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?
75 While at work? _____ (Specify type of place)
 (e) Means of injury _____

18. (a) Signature of funeral director Wm. Schock
 (b) Address Hallsville, Mo.
 19. (a) 11-30 (b) Wm. F. Luettich
 (Date received local registrar) (Registrar's signature)

23. Signature Wm. F. Luettich (M. D. or other)
 Address Centralia Mo Date signed 12/30/40

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

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

M. N. Whitman

Licensed Embalmer No. *3893*

P. O. Address *Columbia*

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

If this body is not embalmed, fact should be so stated above.