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FILLED NOV 24 1941
791

Registration District No. _____

Primary Registration District No. **1003**

1. PLACE OF DEATH:

(a) County _____
(b) City or town **St. Louis**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Deaconess Hospital
(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 **Thomas H. Raybourn (Marcus)**

3. (b) If veteran, name war **No.**
3. (c) Social Security No. **324-01-0595**

4. Sex **Male**
5. Color or race **White**
6. (a) Single, widowed, married, divorced **Single**

6. (b) Name of husband or wife **Single**
6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased **Aug. 21 1912**
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	29	2	0	hr. min.

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

10. Usual occupation **Show Business**

11. Industry or business _____

12. Name **Thomas Raybourn**

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

14. Maiden name **Goldie Furr**

15. Birthplace **Mellott Indiana**
(City, town, or county) (State or foreign country)

16. (a) Informant **Mrs. Thomas Raybourn**

(b) Address **Covington, Ind.**

17. (a) **Removal** (b) Date thereof **10/22/41**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Covington, Ind.**

18. (a) Signature of funeral director **Albert H. Hoppe**

(b) Address **4700 Washington Ave.**

19. (a) **OCT 22 1941** (b) **J. F. Bredek**
(Date read and local authority) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Indiana** (b) County **Fountain**
(c) City or town **Covington**
(If outside city or town limits, write "RURAL")
(d) Street No. **Rural**
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **October** day **21st**
year **1941** hour **12** minute **25 P.** 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 **Internal Hemorrhage** Duration _____
burns of left shoulder, arms and hand received while driving an automobile through a pyramid of burning barrels at a circus and thrill show in the Arena, 5700 Oakland Av., Oct. 19th, 1941, about 8.30-P.M. Accident.

Other conditions _____
(Include pregnancy within 3 months of death)

Major findings: **18/11**
Of operations _____
Of autopsy _____

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) **Accident**

(b) Date of occurrence **10-19-1941**

(c) Where did injury occur? **St. Louis, Mo.**
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?
public place
(Specify type of place) (e) Means of injury _____

23. Signature **Thomas F. Callahan** (M.D. or other)

Address **Security Coroner** Date signed _____

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

MOTHER FATHER

JUL 24 1946

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..... *Walter J. Burnley*

Licensed Embalmer No. *4202*

P. O. Address.....

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, fact should be so stated above.