

WRITE PLAINLY, WITH UNFADING INK. THIS IS A PERMANENT RECORD

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.

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

7454  
 Do not use this space.

FILED FEB 15 1943

1. PLACE OF DEATH

(a) County St. Clair Registration District No. 312

(b) Township Butter Primary Registration District No. 4457

(c) City Laurie City, Mo. (d) Street No. 1 Registered No. 19

(e) Length of residence in city or town where death occurred yrs. 4 mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME Joseph Oscar Rathbun

(a) Residence, No. Laurie City, St. Clair Co., Missouri St.  (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) 1 Married

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Apr 19 1868

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, hrs. or min.
	<u>74</u>	<u>7</u>	<u>26</u>	

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Retired Salesman

9. Industry or business in which work was done, as saw mill, bank, etc.

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) Not Given  
Indiana

13. NAME Joseph Rathbun

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Not Given  
Not Given

15. MAIDEN NAME Louisa Mc Grew

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Not Given  
Not Given

17. INFORMANT (ADDRESS) Marie Wilcox  
Not known R. C. Mo

18. BURIAL, CREMATION, OR REMOVAL  
PLACE Kansas City, Mo DATE 12/15 1942

19. FUNERAL DIRECTOR (NAME) (ADDRESS) H. C. Austin  
Laurie City, Mo

20. FILED Jan. 5, 1943 W. E. Holtz  
Local Registrar.

**MEDICAL CERTIFICATE OF DEATH**

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 12/15/42 1942

22. I HEREBY CERTIFY, That I attended deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_.

I last saw him \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_. Death is said to have occurred on the date stated above, at 1:09 P.M.

The principal cause of death and related causes of importance were as follows:

Killed by train.  
Coroners inquest held.  
Verdict: - Died as a result of an accident unavoidable.

Other contributory causes of importance:

Name of operation \_\_\_\_\_ Date of \_\_\_\_\_

What test confirmed diagnosis? \_\_\_\_\_ Was there an autopsy? 1

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? Not Given  
 (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place.

Manner of injury Killed instantly

Nature of injury \_\_\_\_\_

24. Was disease or injury in any way related to occupation of deceased? \_\_\_\_\_

If so, specify \_\_\_\_\_

(Signed) Farred B. Goodrich, M. D.  
 (Address) Oscar P. O.  
Coroner of St. Clair Co.

11. Thinnie Foster Dept (Licensed Embalmer's Statement on Reverse Side)

RECEIVED

District Health Officer No. 7,

District File Number 1-45-22

Date Filed 2-3-42

b

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 H. C. Austin.....

Licensed Embalmer No. 3609.....

P. O. Address Laurry City 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. 7454

Registration District No. 312

Primary Registration District No. 4457

Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH:

(a) County St. Clair

(b) City or town Louisy City  
(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 \_\_\_\_\_ (Specify whether \_\_\_\_\_)

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) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Joseph O. Rathburn

3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex M 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 Apr. 17 1866  
(Month) (Day) (Year)

8. AGE: Years 74 Months 7 Days 16 If less than one day \_\_\_\_\_ min.

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

10. Usual occupation \_\_\_\_\_

11. Industry or business \_\_\_\_\_

12. Name \_\_\_\_\_

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

14. Maiden name \_\_\_\_\_

15. Birthplace \_\_\_\_\_  
(City, town, or county) (State or foreign country)

16. (a) Informant \_\_\_\_\_ (b) Address \_\_\_\_\_

17. (a) \_\_\_\_\_ (b) Date thereof \_\_\_\_\_  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation \_\_\_\_\_

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

19. (a) \_\_\_\_\_ (b) \_\_\_\_\_  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 12 Day 15 Year 1943 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the decedent from \_\_\_\_\_ to \_\_\_\_\_, 19\_\_\_\_; that I have seen him alive on \_\_\_\_\_, 19\_\_\_\_; and that death occurred on the date and hour stated above.

Immediate cause of death Was hit by passenger train while walking across Rail Road track. No indication of any negligence on part of engineer

Duration \_\_\_\_\_

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

Major findings: 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 12-15-43

(c) Where did injury occur? on Rail Road Track  
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? No

While at work? No (Specify type of place) Means of injury No

23. Signature Jared B. ... (M. D. or other) \_\_\_\_\_

Address Osceola Mo Date signed 4-5-43

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

SUPPLEMENTARY

MOTHER FATHER

