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5-17-39
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23387

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No.
Registrar's No. **6246**

FILED JUL 17 1943
Registration District No. **878**

Primary Registration District No. **1003**

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

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:
ISOLATION HOSPITAL
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **7-7 1/2 to**
In this community **7-8 1/2**. (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **MISSOURI** (b) County.....
(c) City or town **ST. LOUIS**
(If outside city or town limits, write "RURAL")
(d) Street No. **3642-EASTON STREET**
(If rural, give location)
(e) Citizen of foreign country?..... (Yes or No)
If yes, name country.....

3. (a) PRINT FULL NAME **BONNIE FAY RAYBURN**

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

4. Sex **FEMALE** 5. Color or race **WHITE** 6. (a) Single, widowed, married, divorced **INFANT**
6. (b) Name of husband or wife..... 6. (c) Age of husband or wife if alive..... years
7. Birth date of deceased **MARCH 24 1943**
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
3 14 hr. min.

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

10. Usual occupation.....
11. Industry or business.....
MOTHER FATHER { 12. Name **SHELLY RAYBURN**
13. Birthplace **ALABAMA** (City, town, or county) (State or foreign country)
14. Maiden name **IRA JOSEPHINE WESTERN**
15. Birthplace **GEORGIA** (City, town, or county) (State or foreign country)

16. (a) Informant **EDITH V. MINOR**
(b) Address **5600 ARSENAL STREET**
17. (a) (b) Date thereof **7-10-43**
(c) Place: burial or cremation **Central Nat C**
18. (a) Signature of funeral director **Central Nat C**
(b) Address **1841 Cass Ave**
19. (a) **JUL 9 1943** (b) **J. Brudeck**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **JULY** day **8**
year **1943** hour **11** minute **50** A. M.
21. I hereby certify that I attended the deceased from **JULY 7 1943**
to **July 8 1943**, 19..... to **July 8 1943**, 19.....
that I last saw her alive on **July 8 1943** and that death occurred on the date and hour stated above.
Immediate cause of death **Pertussis**

Duration

Due to.....
Due to.....
Other conditions **Broncho pneumonia**
(Include pregnancy within 3 months of death)

Major findings:
Of operations.....
Of autopsy **broncho pneumonia**

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) (e) Means of injury.....
23. Signature **Dr. Max well** (M. D. or other).....
Address **Isolation Hospital** Date signed **7-9-43**

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.....

Licensed Embalmer No.....

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.