

FILED SEP 8 1944

Registration District No. 53

Primary Registration District No. 3010

Registrar's No. 268

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

1. PLACE OF DEATH:

(a) County Leafe Co
(b) City or town Leafe, Gerardian
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: St. Francis Hosp.
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 17 days
(Specify whether years, months or days)
In this community all of Sept 17 days

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County New Madrid
(c) City or town Postleville Mo. 79
(If outside city or town limits, write "RURAL") 6
(d) Street No. 0
(If rural, give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country 1

3. (a) PRINT FULL NAME

RAINE, Ray Jones

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

single

6. (b) Name of husband or wife

—

6. (c) Age of husband or wife if

alive — years

7. Birth date of deceased

June
(Month)

28
(Day)

1944
(Year)

8. AGE:

Years

Months

Days

If less than one day

1

23

hr. —

min. —

9. Birthplace

New Madrid Co. Mo.
(City, town, or county) (State or foreign country)

10. Usual occupation

Nurs

11. Industry or business

Nurs

12. Name

Louis C Jones

13. Birthplace

Leafe Tenn.
(City, town, or county) (State or foreign country)

14. Maiden name

Ray self Tenn.

15. Birthplace

Leafe Tenn.
(City, town, or county) (State or foreign country)

16. (a) Informant

Louis C Jones

(b) Address

Postleville Mo

17. (a) Burial

(b) Date thereof 8-16-44
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation

St. Francis Hosp

18. (a) Signature of funeral director

Wm Hill

(b) Address

Leafe Mo

19. (a)

8-19-44
(Date received local registrar)

(b)

F. H. Phelps
(Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH:

Month 8 day 14
year 1944 hour 10 minute 10 P. M.

21. I hereby certify that I attended the deceased from

7/29 1944 to 8/14 1944
that I last saw him alive on 8/14 1944
and that death occurred on the date and hour stated above.

Immediate cause of death

Malnutrition

Due to

Due to

Other conditions

Spontaneous Pneumonia

Major findings

Of operations

Of autopsy

158

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)

23. Signature

Ray Jones (M. D. or other)
Address Leafe Mo Date signed 8/17/44

1014

RECEIVED

District Health Officer No. 4

District File Number 944-4289

Date Filed 9-7-44

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.