

S. No. 2
M-5-43
5-17-39
p 1 X38671

FILED NOV 18 1944

Registration District No. **187**

Primary Registration District No. **5675-**

Registrar's No. **31**

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

1. PLACE OF DEATH

(a) County **Linn**

(b) City or town **Rural**
(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 **1**
(Specify whether)

In this community _____
years, months or days

3. (a) PRINT FULL NAME **J. W. Raybourn**

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 **Oct 3 1888**
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
56	—	27	hr. min.

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

10. Usual occupation **Farmer**

11. Industry or business

12. Name **James Raybourn**

13. Birthplace **Annada Mo**
(City, town or county) (State or foreign country)

14. Maiden name **Ellen Lacey**

15. Birthplace **unknown Mo**
(City, town or county) (State or foreign country)

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

(b) Address **Annada Mo**

17. (a) **Rural** (Burial, cremation, or removal) (b) Date thereof **Nov-44**
(Month) (Day) (Year)

(c) Place: burial or cremation **Clarksville Cemetery**

18. (a) Signature of funeral director **W. B. Rodley**

(b) Address **Ellettsville**

19. (a) **Nov 6 1944** (Date received local registrar) (b) **G. B. Williams** (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Mo** (b) County **Linn**

(c) City or town **Ellettsville**
(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 **Oct** day **30** year **1944** hour **4** minute **30** a. m.

21. I hereby certify that I attended the deceased from **Oct 30** 19**44**, to **Oct 30** 19**44**, that I last saw him alive on **Oct 30** and that death occurred on the date and hour stated above.

Immediate cause of death **Very suddenly from Coronary thrombosis**

Due to _____

Due to **94a**

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) _____

(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)

(b) Means of injury _____

23. Signature **J. V. Keelmy** (M. D. or other)

Address **Ellettsville Mo** Date signed **11-21-44**

1193

RECEIVED

District Health Officer No. 9,

District File Number.....

Date Filed 11-8-44

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.....

W. O. Bradley

Licensed Embalmer No.....

3966

P. O. Address.....

E. Perry

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.