

FILED JAN 10 1945  
Registration District No. ....

Primary Registration District No. 44-72 6.19 81

Registrar's No. 43

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

1. PLACE OF DEATH:

(a) County Albin Morality Rawlings Saline  
(b) City or town Rural Cambridge Township  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
X  
(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 72 years  
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State MO (b) County Saline 97  
(c) City or town Rural 6  
(If outside city or town limits, write "RURAL") 6  
(d) Street No. ....  
(If rural, give location)  
(e) Citizen of foreign country? Yes (Yes or No)  
If yes, name country England 6

3. (a) PRINT FULL NAME

Albin Morality Rawlings

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

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced, widowed  
6. (c) Age of husband or wife if alive 2 years

7. Birth date of deceased May-18-1863  
(Month) (Day) (Year)

8. AGE: Years 81 Months 7 Days 2 If less than one day hr. min.

9. Birthplace Hindon, England (City, town, or county) (State or foreign country) 4

10. Usual occupation Stove Salesman Retired

11. Industry or business

12. Name Mortality Rawlings  
13. Birthplace England (City, town, or county) (State or foreign country) 4  
14. Maiden name Mary Moriah Bayly  
15. Birthplace England (City, town, or county) (State or foreign country) 4

16. (a) Informant Mrs R W Bridges  
(b) Address Fort Worth Texas

17. (a) Burial (b) Date thereof 12/22/44  
(Burial, cremation, or other) (Month) (Day) (Year)  
(c) Place: burial or cremation Stater, City, Cemetery

18. (a) Signature of funeral director Stater Mrs  
(b) Address Stater Mrs

19. (a) 12-25-44 (b) Mrs John Giger  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec day 20th  
year 1944 hour 8 minute 55 P.M.

21. I hereby certify that I attended the deceased from June 1944 to Dec 20 1944  
that I last saw him alive on Dec 20 1944  
and that death occurred on the date and hour stated above.

Immediate cause of death Cancer Sarcoma, with generalized metastases  
Due to metastases 7 mo

Due to ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

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? \_\_\_\_\_

(Specify type of place) (Specify means of injury)  
While at work? \_\_\_\_\_  
23. Signature W. M. Burney (M.D. or other) 12-21-44  
Address Stater, Mo Date signed 12-21-44

FEB 3 1974

RECEIVED  
District Health Officer No. 8,  
District File Number \_\_\_\_\_  
Date Filed 1-9-75

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 James Jones  
Licensed Embalmer No. 3143  
P. O. Address Water...

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.

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. Jan  
Registrar's No. 43

Registration District No. 222 Primary Registration District No. 6087

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

1. PLACE OF DEATH:

(a) County Salisbury

(b) City or town Cambridge  
(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 \_\_\_\_\_  
years, months or days

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 Albert M. Rawlings

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec day 20  
year 1944 hour \_\_\_\_\_ minute \_\_\_\_\_ 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 \_\_\_\_\_

4. Sex M 5. Color or race W 6. (a) Single, widowed, married, divorced W

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased May 18 1881  
(Month) (Day) (Year)

Due to Heart of Cancer was behind right ear.

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

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

8. AGE: Years 81 Months 7 Days \_\_\_\_\_ If less than one day, \_\_\_\_\_ hr. \_\_\_\_\_ min.

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

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

Major findings: Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

PHYSICIAN \_\_\_\_\_  
Underline the cause to which death should be charged statistically.

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)

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) \_\_\_\_\_ (a) Means of injury \_\_\_\_\_

23. Signature O. A. McJannet (M. W. or father) \_\_\_\_\_  
Address \_\_\_\_\_ Date signed \_\_\_\_\_

SUPPLEMENTAL

S-42209 1944

FEB 5 1944