

FILED OCT 25 1945 318

Registration District No. _____ Primary Registration District No. _____ Registrar's No. 3070

1. PLACE OF DEATH:

(a) County _____
(b) City or town St. Louis, Mo.
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution St. Louis Childrens Hosp.
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 3 days.
In this community _____ 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. 5711 1/2 Selman
(If rural, give location)
(e) Citizen of foreign country? no. (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME James Stephens Rayburn

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

4. Sex male 5. Color or race white 6. (a) Single, widowed, married, divorced 1

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

7. Birth date of deceased September 2, 1945
(Month) (Day) (Year)

8. AGE: Years _____ Months 1 Days 17 If less than one day _____ hr. _____ min.

9. Birthplace St. Louis, Mo. (City, town, or county) (State or foreign country) 0

10. Usual occupation _____

11. Industry or business _____

12. Name Harry Rayburn

13. Birthplace Missouri (City, town, or county) (State or foreign country) 0

14. Maiden name Mary Alice Amate

15. Birthplace Missouri (City, town, or county) (State or foreign country) 0

16. (a) Informant Dr. Lee

(b) Address 500 So. Kings Highway

17. (a) Burial (b) Date thereof 10-20-45
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Memorial Park Cem

18. (a) Signature of funeral director J. F. Bredeh

(b) Address 1225 Quincy Blvd.
19. (a) OCT 20 1945 (b) J. F. Bredeh
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month October day 19th
year 1945 hour 7 minute 45 A.M.

21. I hereby certify that I attended the deceased from 10-16, 1945, to 10-19, 1945
that I last saw him alive on 10-19, 1945
and that death occurred on the date and hour stated above.

Immediate cause of death Intracranial hemorrhage
meningeal

Due to _____

Due to _____

Other conditions 1/200
(Include pregnancy within 3 months of death)

Major findings: Of operations _____

Of autopsy _____

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 K. J. B. G. Haver (M. D. or other) _____

Address 10 N. Kings Highway Date signed _____

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

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.....

Not Embalmed

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.