

V. S. No. 2
FORM-2-43
Rev. 5-17-39
X35697

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

33907

State File No. _____

FILED OCT 25 1947

Registration District No. _____

Primary Registration District No. 5208

Registrar's No. 20

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

1. PLACE OF DEATH:

(a) County Carroll
(b) City or town Rural Harrison Twp
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Home 4 Miles NE Tina
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution
In this community all His Life (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Carroll
(c) City or town Hale Missouri (Rural)
(If outside city or town limits, write "RURAL")
(d) Street No. 4 Miles NE Tina
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Arthur Fielding Rawlins,

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

4. Sex M 5. Color or race W 6. (a) Single, widowed, married, divorced married
(b) Name of husband or wife Gladya Rawlins 6. (c) Age of husband or wife if alive 47 years
7. Birth date of deceased July 29, 1899 (Month) (Day) (Year)

8. AGE: Years 48 Months 2 Days 13 If less than one day hr. _____ min. _____

9. Birthplace Livingston Co. Missouri (City, town or county) (State or foreign country)

10. Usual occupation Farmer

11. Industry or business _____

MOTHER FATHER

12. Name Fielding J. Rawlins

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

14. Maiden name Mollie Allmon

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

16. (a) Informant Mrs Gladya Rawlins

(b) Address Hale, Missouri

17. (a) Burial (b) Date thereof 10/14/47 (Month) (Day) (Year)

(c) Place: burial or cremation Walton Missouri

18. (a) Signature of funeral director Clifford W Austin

(b) Address Tina, Missouri

19. (a) 10-14-47 (Date received local registrar) (b) Mrs Rex Henderson (Registrar's signature) (Date)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct day 12 year 1947 hour 10:00 minute 0 M.

21. I hereby certify that I attended the deceased from before noon, 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 Stroke - 130 stroke Duration _____
Stroke - Small Fracture + Crushed Chest

Due to Injuries received from a falling tree that he and his brother were
Down Cutting

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) Accident 17
(b) Date of occurrence 10-12-47

(c) Where did injury occur? Carroll Mo (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? Farm

While at work? Yes (Specify type of place) (e) Means of injury Stroke

23. Signature Charles R. Roth (M.D. or other) Carroll Mo
Address Carroll Mo Date signed 10-12-47

RECEIVED

District Health Officer No. 8,

District File Number

Date Filed

10-24-47

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.....

Clifford W. Austin

..... Licensed Embalmer No. *3233*

P. O. Address *Tenai, Missouri*

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.