

S. No. 300
OM-10-47
ev. 5-17-39
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FEDERAL SECURITY AGENCY
National Office of Vital Statistics

FILED SEP 24 1948

Registration District No. 239

MISSOURI CERTIFICATE OF HEALTH
STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 5825

State File No. 30485

Registrar's No. 35

9-20-48
99
and 599

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

1. PLACE OF DEATH:

(a) County 72 N. Madrid

(b) City or town Catron Mo.
(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 years, months or days)

3. (a) PRINT FULL NAME Earg Lee. Raston

3. (b) If veteran, name war Non

3. (c) Social Security No. _____

4. Sex M

5. Color or race Co.

6. (a) Single, widowed, married, divorced 0

6. (b) Name of husband or wife Earnest Raston

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

7. Birth date of deceased: 7-16-1899
(Month) (Day) (Year)

8. AGE: Years 0 Months 1 Days 25 If less than one day hr. _____ min. _____

9. Birthplace: _____ (City, town, or county) _____ (State or foreign country)

10. Usual occupation Catron Pa.

11. Industry or business Non

MOTHER FATHER

12. Name Earnest Raston

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

14. Maiden name Priscilla Raston

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

16. (a) Informant Earnest Raston

(b) Address Catron Mo.

17. (a) Burial (Burial, cremation, or removal)

(b) Date thereof 9-12-48 (Month) (Day) (Year)

(c) Place: burial or cremation Catron cemetery

18. (a) Signature of funeral director L. O. Hill

(b) Address Lilbourn Mo.

19. (a) 9-17-48 (Date received local registrar)

(b) D. K. Upstater (Registrar's signature) (c) 107

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County New Madrid

(c) City or town Catron (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 _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 9 day 11
year 48 hour 3 minute PM

21. I hereby certify that I attended the deceased from 9-10-48, 19____, to 9-11-48, 19____;
that I last saw her alive on _____, 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death _____

Pneumonia

Due to _____

Due to _____

Other conditions _____ (Include pregnancy within 3 months of death)

Major findings:
Of operations _____

Of autopsy 119A

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)

(e) Means of injury _____

23. Signature L. O. Hill (M. D. or other) MO

Address Lilbourn Mo. Date signed 9/17/48

SEP 24 1947

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 *Ed Hill*
Not - Embalmed.

Licensed Embalmer No. *2687*

P. O. Address *Silbourn Mo.*

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.