MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

Do not use this space.

30858

1. PLACE OF DEATH

County: Jasper — Registration District No. 417

Township: — Primary Registration District No. 3021

City: Webb City (No. ..... St. ..... Ward)

File No. ..... Registered No. 97

2. FULL NAME Carrie M. Rains

(a) Residence. No. 5 E. France St., ... Ward. (Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U.S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write* the word)
Male	White	Married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF ~~(OR) WIFE OF~~ Elosie Rains

6. DATE OF BIRTH (MONTH, DAY AND YEAR) April 27 1887

7. AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	39	4	11	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Empire District

(b) General nature of industry, business, or establishment in which employed (or employer): Electric Co.

(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) Lawrence County (STATE OR COUNTRY) Missouri

PARENTS

10. NAME OF FATHER J. N. Rains

11. BIRTHPLACE OF FATHER (CITY OR TOWN) ..... (STATE OR COUNTRY) Ind.

12. MAIDEN NAME OF MOTHER Lou Griffitts

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) ..... (STATE OR COUNTRY) Missouri

14. INFORMANT Mrs. Elosie Rains (Address) Webb City Mo.

15. FILED 9/7 1928 R. M. Stormont REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Sept 7 1928

17. I HEREBY CERTIFY, That I attended deceased from 9/3 1928, to 9/7 1928, that I last saw ~~him~~ alive on 9/6 1928, and that death occurred, on the date stated above, at 2 P.M. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Bronchial Pneumonia

109A Total (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (SECONDARY) ..... (duration) ..... yrs. ..... mos. ..... ds.

18. WHERE WAS DISEASE CONTRACTED IF NOT AT PLACE OF DEATH? .....

DID AN OPERATION PRECEDE DEATH? no DATE OF .....

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS? Clinical

(Signed) B. A. Dunbaugh, M. D.

9/7, 1928 (Address) Webb City Mo

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL	DATE OF BURIAL
Cronogue Cemetery	9/9 1928
20. UNDERTAKER	**ADDRESS**
Webb City Und. Co.	Webb City

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.