

1939 JUL 18 1939

MISSOURI STATE BOARD OF HEALTH

BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

22483
Do not use this space.

1. PLACE OF DEATH

(a) County LACLEDE Registration District No. 449
 (b) Township..... Primary Registration District No. 4267 Registered No.....
 (c) City LEDANON (d) Street No. Wallace Hospital St.
 (If death occurred in Hospital or Institution, write its name instead of street and number)
 (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U.S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME

MOSES RAYLE
 (a) Residence, No. Old Town Ledanon Mo. St. (If nonresident, give city or town and State)
 (Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M 4. COLOR OR RACE B 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) MARRIED

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF ELLA GIVENS

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) MAR 15, 1897

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
52 3 4

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. LABORER
 9. Industry or business in which work was done, as saw mill, bank, etc.
 10. Date deceased last worked at this occupation (month and year)
 11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) WAXNESVILLE MO

FATHER 13. NAME John RAYLE

FATHER 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) MO

MOTHER 15. MAIDEN NAME Mrs. Miller

MOTHER 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Mo.

17. INFORMANT (ADDRESS) Walter Cherry

18. BURIAL, CREMATION, OR REMOVAL PLACE Ledanon Mo. DATE June 6, 39

19. FUNERAL DIRECTOR (NAME) (ADDRESS) PALMER'S LEDANON MO.

20. FILED 6-8-39 J. A. M. Coult Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) June 5, 1939

22. I HEREBY CERTIFY That I attended deceased from June 4, 1939, to June 5, 1939.
 I first saw him alive on June 4, 1939. Death is said to have occurred on the date stated above, at 1:30 PM.
 The principal cause of death and related causes of importance were as follows:

obstruction of bowel
Heavy lifting 12th 6'

Other contributory causes of importance: Obstruction
 Name of operation Obstruction Date of June 5
 What test confirmed diagnosis? Xray Was there an autopsy? no

23. If death was due to external causes (violence), fill in also the following:
 Accident, suicide, or homicide? _____ Date of injury _____, 19____
 Where did injury occur? _____ (Specify city or town, county, and State)
 Specify whether injury occurred in industry, in home, or in public place.

Manner of injury _____
 Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased? _____
 If so, specify _____
 (Signed) J. L. Benge, M. D.
 (Address) 404 L. Leander, Mo.

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

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.

53
2
1

FORM I X-16803

RECEIVED

District Health Officer No.

District File Number 7-38-16

Date Filed 7-14-37

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.....

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, above space should be left blank.