

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUSMISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

28566

State File No.

NEW SEP 8 1939

Registration District No. 72Primary Registration District No. 4041Registrar's No. 55

1. PLACE OF DEATH:

- (a) County Boone
 (b) City or town Centralia
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution Residence ✓
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 15 yrs (Specify whether
 In this community years, months or days)

8. (a) PRINT
FULL NAMEWilliam Clay Rainey 50th

8. (b) If veteran,

name war ✓

8. (c) Social Security

No. ✓

4. Sex

Male

5. Color or

race White

6. (a) Single, widowed, married,

divorced Widowed

6. (b) Name of husband or wife

6. (c) Age of husband or wife if

alive years

7. Birth date of deceased

Nov
(Month)7
(Day)1861
(Year)

8. AGE:

Years

Months

Days

If less than one day

77
9
17

hr. min.

9. Birthplace

Carrollton
(City, town, or county)Illinois
(State or foreign country)

10. Usual occupation

Retired Farmer

11. Industry or business

John Rainey

MOTHER FATHER

12. Name

Carrollton

13. Birthplace

Kate Phaup
(City, town, or county)Ill.
(State or foreign country)

14. Maiden name

Carrollton
(City, town, or county)Illinois
(State or foreign country)

15. Birthplace

John Rainey
(City, town, or county)Illinois
(State or foreign country)

16. (a) Informant's own signature

John Rainey

(b) Address

Columbia17. (a) Burial

(b) Date thereof

Aug 26 1939
(Month) (Day) (Year)

(c) Place: burial or cremation

Carrollton Illinois Ill.

18. (a) Signature of funeral director

Centralia Mo 36

(b) Address

9/6/3919. (a) 9/6/39

(Date received local registrar)

(b) F. H. Broderick

(Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

- (a) State Mo (b) County Boone
 (c) City or town Centralia
 (If outside city or town limits, write "RURAL")
 (d) Street No. 91
 (If rural, give location)
 (e) If foreign born, how long in U. S. A. 24 years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug day 24
 year 1939 hour 12:30 minute 0 M.

21. I hereby certify that I attended the deceased from 8/24/39 to 8/24/39, 19...
 that I last saw him alive on 8/24/39, 19...
 and that death occurred on the date and hour stated above.

Immediate cause of death

Cerebral Hemorrhage 8/24

Duration

Due to

Hypertension?

Due to

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) _____
 (b) Date of occurrence _____
 Where did injury occur? _____
 (City or town) (County) (State)
 (c) Did injury occur in or about home, on farm, in industrial place, in public place?

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

23. Signature W. H. Broderick (M. D. or other)Address Centralia Mo Date signed 8/24/39

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. *2589*

P. O. Address *Centralia 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, above space should be left blank.