

1939 OCT 16 1939

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

33335  
Do not use this space.

1. PLACE OF DEATH

(a) County Ray Registration District No. 743  
(b) Township Antwerp Primary Registration District No. 11105 Registered No. \_\_\_\_\_  
(c) City Orion Mo (d) Street No. \_\_\_\_\_ 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

500 LAFAYETTE GAIN  
(a) Residence, No. Orion Mo St.  (Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX <u>Male</u>	4. COLOR OR RACE <u>White</u>	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) <u>Married</u>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF <u>Husband Mattie Cora Cain</u>		
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) <u>Sept 8 1868</u>		
7. AGE	YEARS <u>71</u>	MONTHS <u>1</u>
	DAYS <u>1</u>	IF LESS than 1 day, _____ hrs. or _____ min.
OCCUPATION	8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. <u>Retired Merchant</u>	
	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) <u>8</u>	
	11. Total time (years) spent in this occupation <u>15 years</u>	
12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Ray County Mo</u>		
FATHER	13. NAME <u>Booth Cain</u>	
	14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Virginia</u>	
MOTHER	15. MAIDEN NAME <u>Agnes Buchanan</u>	
	16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Virginia</u>	
17. INFORMANT (ADDRESS) <u>Mattie Cora Cain</u> <u>Orion Mo</u>		
18. BURIAL, CREMATION, OR REMOVAL PLACE <u>Todd Chapel</u> DATE <u>11 Sept 1939</u>		
19. FUNERAL DIRECTOR (NAME) (ADDRESS) <u>E. Thurman</u> <u>Richmond Mo.</u>		
20. FILED _____ 19____ Local Registrar. <input checked="" type="checkbox"/>		

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 9/9 - 1939

22. I HEREBY CERTIFY, That I attended deceased from July 20, 1936, to Apr. 29, 1936  
I last saw him alive on 9-7, 1939. Death is said to have occurred on the date stated above, at 6:15 P.M.  
The principal cause of death and related causes of importance were as follows:  
Multiple Arteritis -  
Partial Paralysis of  
Arms & Legs -  
Organic Heart -  
191

Other contributory causes of importance:  
Arterio Sclerosis -  
Cardiorenal Vascular  
Attending Physician in

Name of operation: None Date of: ✓  
What test confirmed diagnosis? ✓ 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? NO  
If so, specify \_\_\_\_\_  
(Signed) Dr. Ruth Street, M. D.  
957 (Address) Orion Mo

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



FILL IN ANSWERS TO ALL SPACES  
CHECKED IN RED PENCIL.

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

33335-

Do not use this space.

1. PLACE OF DEATH

(a) County Ray Registration District No. 743  
 (b) Township Orwick Primary Registration District No. 1443-  
 (c) City Orwick (d) Street No. \_\_\_\_\_ Registered No. \_\_\_\_\_  
 (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

(a) Residence, No. Lafayette Cain 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 W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) W

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Mattie Vera Cain

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) 9-8 1868

7. AGE YEARS MONTHS DAYS If LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.  
71 1

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Retired  
 9. Industry or business in which work was done, as saw mill, bank, etc. merchant  
 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) Ray Co Mo

13. NAME Brooth Cain

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Virginia

15. MAIDEN NAME Agnes P. Shuman

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Virginia

17. INFORMANT (ADDRESS) Mattie Vera Cain  
Orwick Mo

18. BURIAL, CREMATION, OR REMOVAL PLACE Good Chapel DATE 9-11 1939

19. FUNERAL DIRECTOR (ADDRESS) E. J. Harrison  
Ray Mo

20. FILED Nov 18 1939 E. J. Harrison  
Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 9-9 1939

22. I HEREBY CERTIFY, That I attended deceased from 2-20 to Apr 29 1938

I last saw him alive on 9-7 1939 Death is said to have occurred on the date stated above, at 6:15 p.m.

The principal cause of death and related causes of importance were as follows:

multiple Arteritis  
Partial paralysis  
Arteriosclerosis + High  
Organic Heart

Other contributory causes of importance:

Arteriosclerosis  
Cardiac Renal Disease  
attending physician

Name of operation \_\_\_\_\_ Date of \_\_\_\_\_

What test confirmed diagnosis? \_\_\_\_\_ Was there an autopsy? \_\_\_\_\_

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) Paul Chesty, M. D.

(Address) Orwick Mo

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. REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.

