

Registration District No. 1095Primary Registration District No. 3310

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Cooper
(b) City or town St. James
(If outside city or town limits, write "RURAL" and name of township)(c) Name of hospital or institution 2
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____ (Specify whether)

In this community 77 yr _____ (Specify whether)
years, months or days 11.173. (a) PRINT FULL NAME Frank David Raw

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex Male 5. Color or race W 6. (a) Single, widowed, married, divorced ✓

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

7. Birth date of deceased Dec 15 - 1862
(Month) (Day) (Year)8. AGE: Years 77 Months _____ Days 29 If less than one day hr. _____ min. _____9. Birthplace Cooper Co Mo
(City, town, or county) (State or foreign country)10. Usual occupation Farmer

11. Industry or business

12. Name Frank Raw13. Birthplace Germany
(City, town, or county) (State or foreign country)14. Maiden name Agnie Schmidt15. Birthplace Germany
(City, town, or county) (State or foreign country)16. (a) Informant's own signature Mary Raw(b) Address California Mo17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/17/40
(Month) (Day) (Year)(c) Place: burial or cremation Catholic Cem California18. (a) Signature of funeral director William F. ...(b) Address California Mo19. (a) 2-10-40 (Date received local registrar) (b) J. T. Martin (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County _____

(c) City or town _____
(If outside city or town limits, write "RURAL")(d) Street No. _____
(If rural, give location)

(e) If foreign born, how long in U. S. A. ? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan. day 13
year 1940 hour _____ minute _____ M.21. I hereby certify that I attended the deceased from Jan. 10
19 40 to Jan 12, 19 40
that I last saw him alive on Jan. 12, 19 40
and that death occurred on the date and hour stated above.Immediate cause of death Carcinoma of R. Kidney.
Duration _____Due to _____
Due to 51Other conditions: _____
(Include pregnancy within 3 months of death)Major findings: _____
Of operations _____

Of autopsy _____

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)
Means of injury 323. Signature K. F. Dennis (M. D. or other) 80Address California Mo Date signed 1/15/40

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.

RECEIVED
District Health Officer No. 3
Date Filed _____
Apprentice File Number _____
M/1/10

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 H. E. Friedmeyer
Licensed Embalmer No. 2854
P. O. Address California ms

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.

FILL IN ANSWERS TO ALL SPACES
CHECKED IN RED PENCIL.

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

2180.
Do not use this space.

1. PLACE OF DEATH
- (a) County Cooper Registration District No. 1095
(b) Township 8, Miller Primary Registration District No. 3310 Registered No. _____
(c) City _____ (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 Frank David Rau
- (a) Residence, No. _____ 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

MEDICAL CERTIFICATE OF DEATH

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

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 1-13 1940

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

22. I HEREBY CERTIFY, That I attended deceased from _____ 19____ to _____ 19____

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

I last saw h. _____ alive on _____ 19____. Death is said to have occurred on the date stated above, at _____ m.

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
77 29

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

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.
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 _____

Date of onset _____

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) _____

Other contributory causes of importance: _____

FATHER 13. NAME _____

Name of operation _____ Date of _____

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

What test confirmed diagnosis? _____ Was there an autopsy? _____

MOTHER 15. MAIDEN NAME _____

23. If death was due to external causes (violence), fill in also the following: Accident, suicide, or homicide? _____ Date of injury _____ 19____

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

Where did injury occur? _____ (Specify city or town, county, and State)

17. INFORMANT (ADDRESS) _____

Specify whether injury occurred in industry, in home, or in public place.

18. BURIAL, CREMATION, OR REMOVAL PLACE _____ DATE _____ 19____

Manner of injury _____

Nature of injury _____

19. FUNERAL DIRECTOR (ADDRESS) _____

24. Was disease or injury in any way related to occupation of deceased? _____

If so, specify _____ (Signed) W. J. O'Banion, M. D.

20. FILED 2-10 1940 J. C. Martin Local Registrar

(Address) California

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

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SUPPLEMENTARY

