V. S. No. 2
DM—11-10-39
Rev. 5-17-39
I X21492

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 9489

Registration District No. 791 Primary Registration District No. 1003 Registrar's No. 2972

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:

(a) County St. Louis, Mo

(b) City or town (If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: BARNES HOSPITAL (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 5 months and 7 days (Specify whether In this community years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Illinois (b) County

(c) City or town Salem NR (If outside city or town limits write "RURAL")

(d) Street No. 426 East Locust (If rural, give location)

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

3. (a) PRINT FULL NAME Tom Vernon Raney

3. (b) If veteran, name war None

3. (c) Social Security No. 442-05-7774

4. Sex Male

5. Color or race White

6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Katie Raney

6. (c) Age of husband or wife if alive 49 years

7. Birth date of deceased Dec. (Month) 25 (Day) 1889 (Year)

8. AGE: Years 50 Months 3 Days 3 If less than one day hr. min.

9. Birthplace Coffman Co. (City, town, or county) Texas (State or foreign country)

10. Usual occupation Oil Driller

11. Industry or business

FATHER
12. Name Thomas Raney
13. Birthplace (City, town, or county) Texas (State or foreign country)

MOTHER
14. Maiden name Unknown
15. Birthplace Unknown (City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Katie Raney

(b) Address Salem, ~~Mo.~~ Illinois

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-30-40 (Month) (Day) (Year)

(c) Place: burial or cremation Lake Charles Cem.

18. (a) Signature of funeral director Albert H. Hoppe

(b) Address 4700 Washington Ave.

19. (a) MAR 29 1940 (Date received local registrar) J. F. Bullock (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 28 year 1940 hour 4 00 minute A M.

21. I hereby certify that I attended the deceased from October 21, 1939, to March 28, 1940 that I last saw him alive on March 28, 1940 and that death occurred on the date and hour stated above.

Immediate cause of death Pulmonary abscess, multiple (non-tuberculous) N.M.D.

Due to ~~[illegible]~~

Due to

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations

Of autopsy

Duration

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

(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? (Specify type of place)

While at work? (e) Means of injury?

23. Signature O. N. Anderson (M. D. or other)

Address BARNES HOSPITAL Date signed 3-28-40

(Licensed Embalmer's Statement on Reverse Side)

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 Guy W Wilkinson

Licensed Embalmer No. 3575

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.