

No. 2
13-40
17-39
X23159

DEPARTMENT OF COMMERCE

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **32126**

Registration District No. ~~4359~~

Primary Registration District No. ~~4359~~ **4359**

Registrar's No. _____

1. PLACE OF DEATH:

(a) County New Madrid
(b) City or town Risco, Louisiana State
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether)
In this community life 1 years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County New Madrid
(c) City or town Risco 07th
(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.? 0 years.

3. (a) PRINT FULL NAME Ray Dee Rawson

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

4. Sex male 5. Color or race wh 6. (a) Single, widowed, married, divorced 0

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

7. Birth date of deceased December 24, 1939
(Month) (Day) (Year)

8. AGE: Years 2 Months 9 Days 17 If less than one day _____ hr. _____ min.

9. Birthplace Risco, Missouri
(City, town, or county) (State or foreign country)

10. Usual occupation _____

11. Industry or business _____

12. Name George Rawson

13. Birthplace Mississippi
(City, town, or county) (State or foreign country)

14. Maiden name Mary Sanders

15. Birthplace Mississippi
(City, town, or county) (State or foreign country)

16. (a) Informant George Rawson

(b) Address Risco, Mo.

17. (a) burial (b) Date thereof 10-12-1941
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Kewanee, Mo.

18. (a) Signature of funeral director Permigan Funeral Home

(b) Address Malden Mo.

19. (a) 10/13/41 (b) W. B. Camp
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month October day 11
year 1941 hour 6:00 minute — A.M.

21. I hereby certify that I attended the deceased from October 10th, 1941, to October 10, 1941; that I last saw him alive on October 10, 1941; and that death occurred on the date and hour stated above.

Immediate cause of death Laryngeal Diphtheria 3 days

Due to _____

Due to 10

Other conditions none
(Include pregnancy within 3 months of death)

Major findings: Of operations no operation
Of autopsy no 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) (e) Means of injury _____

23. Signature W. B. Camp (M. D. or other) M.D.
Address Risco, Missouri Date signed Oct 11, 1941

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

2000

OCT 14 1941

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.....

Not embalmed

....., 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, fact should be so stated above.**