

1. PLACE OF DEATH:

(a) County
(b) City or town **St. Louis, Missouri**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Enroute St. Louis City Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **3**
(Specify whether
In this community _____
years, months or days)

3. (a) PRINT FULL NAME **Sam L. Rairigh**

3. (b) If veteran, name war **None** 3. (c) Social Security No. **Unknown**

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

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

7. Birth date of deceased **August 4 1895**
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
51 6 20 hr. min.

9. Birthplace **Pastoria Arkansas**
(City, town, or county) (State or foreign country)

10. Usual occupation **Factory worker**

11. Industry or business _____

12. Name **John S. Rairigh**

13. Birthplace **Indiana County Pennsylvania**
(City, town, or county) (State or foreign country)

14. Maiden name **Annie Lindsey**

15. Birthplace **Pastoria Arkansas**
(City, town, or county) (State or foreign country)

16. (a) Informant **John D. Rairigh**

(b) Address **100 No. Broadway, St. Louis, Missouri**

17. (a) **Removal** (b) Date thereof **2/25/47**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Pine Bluff, Arkansas**

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

(b) Address **4700 Washington Blvd.**

19. (a) **FEB 26 1947** (b) **J. F. Predeck**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County _____
(c) City or town **St. Louis**
(If outside city or town limits, write "RURAL")
(d) Street No. **1368 Granville Place.**
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Feb** day **23**
year **1947** hour **9** minute **20 P.** M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;

that I last saw him _____ alive on _____, 19____; and that death occurred on the date and hour stated above.

Immediate cause of death **External hemorrhage from multiple stab wounds of back, arms and neck. He was inflicted with a knife in the home 3810 Chestnut Drive, around 3:00 PM Sept. 23 1947.**

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 **Feb 23 1947**

(c) Where did injury occur? _____
(City or town) (County) (State)

(d) Did injury occur in or about home, or farm, in industrial place, in public place? **Home**

(Specify type of place) (e) Means of injury **knife**

23. Signature **Patrick E. Taylor** (M.D. or other) **3**

Address **Deputy Coroner** Date signed **2-26-47**

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

APR 4 1947

POST

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.....

.....
working under my personal supervision.

..... Registered Apprentice No.....

Signed *J. Allen Davis Jr*

..... Licensed Embalmer No. *4053*.....

..... P. O. Address *St. Louis*.....

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.