

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.

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

1 PLACE OF DEATH

County Camden
Township Jackson
or
Village
or
City

Registration District No. 119
Primary Registration District No. 5721

File No. 14054
Registered No.

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME John L. Rainwater

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 SINGLE MARRIED married WIDOWED OR DIVORCED (Write the word)

6 DATE OF BIRTH June 7, 1879
(Month) (Day) (Year)

7 AGE 37 yrs 8 mos 27 ds. If LESS than 1 day.....hrs. or.....min.?

8 OCCUPATION (a) Trade, profession, or particular kind of work Farmer (b) General nature of industry business or establishment in which employed (or employer) 108

9 BIRTHPLACE (City or town, State or foreign country) Missouri

PARENTS
10 NAME OF FATHER George Rainwater
11 BIRTHPLACE OF FATHER (City or town, State or foreign country) Mo
12 MAIDEN NAME OF MOTHER Jane McCallum
13 BIRTHPLACE OF MOTHER (City or town, State or foreign country) Tenn

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) George Rainwater
(Address) Montreal Mo

15 Filed Apr 9, 1917 Dr. Clarke Registrar

7 MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Apr 6, 1917
(Month) (Day) (Year)

17 I HEREBY CERTIFY, that I attended deceased from Mar 20, 1917, to Apr 6, 1917, that I last saw h. l. m. alive on Apr 6, 1917, and that death occurred, on the date stated above, at 2:30 m.

The CAUSE OF DEATH* was as follows:
Lobar Pneumonia
W
(Duration)..... yrs..... mos..... 4 ds.

CONTRIBUTORY (Secondary) Measles
(Duration)..... yrs..... mos..... 14 ds.
(Signed) Dr. Clarke M. D.
Apr 6, 1917 (Address) Montreal Mo

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.
18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death..... yrs..... mos..... ds. In the State..... yrs..... mos..... ds.
Where was disease contracted if not at place of death?
Former or usual residence.....

19 PLACE OF BURIAL OR REMOVAL Frederick Cem DATE OF BURIAL Apr 7, 1917
20 UNDERTAKER me ADDRESS X