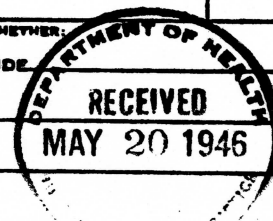


NOTE THE INFORMATION CALLED FOR ON THE REVERSE SIDE

| 1. PLACE OF DEATH   |  | TEXAS DEPARTMENT OF HEALTH<br>BUREAU OF VITAL STATISTICS<br>STANDARD CERTIFICATE OF DEATH |  | 17558   |                         |
|---|--|---|--|---|-------------------------|
| STATE OF TEXAS  |  | COUNTY OF <u>Galveston</u>  |  |   |                         |
| CITY OR PRECINCT NO. <u>Galveston, Tex</u>  |  | U.S. Marine Hospital, Galveston, Texas  |  | GIVE STREET AND NUMBER OR NAME OF INSTITUTION             |                         |
| 2. FULL NAME OF DECEASED  |  | DEAN RAINWATER  |  |   |                         |
| LENGTH OF RESIDENCE   |  | Non-resident  |  |   |                         |
| WHERE DEATH OCCURRED  |  | YEARS MONTHS DAYS (SOCIAL SECURITY NO. <u>494-05-8928</u> )                               |  |   |                         |
| RESIDENCE OF THE DECEASED   |  | STREET AND NO. <u>1357 San Felipe Cts</u>   |  | CITY <u>Houston</u> COUNTY <u>Harris</u> STATE <u>Tex</u> |                         |
| PERSONAL AND STATISTICAL PARTICULARS  |  |   |  |   |                         |
| 3. SEX  |  | 4. COLOR OR RACE  |  | 17. DATE OF DEATH   |                         |
| M   |  | W   |  | April 22, 1946  |                         |
| 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (WRITE THE WORD) <u>widowed</u>                             |  |   |  |   |                         |
| 6. DATE OF BIRTH <u>March 31, 1894</u>  |  |   |  |   |                         |
| 7. AGE YEARS MONTHS DAYS IF LESS THAN 1 DAY   |  |   |  |   |                         |
| 52 0 21 HOURS MIN   |  |   |  |   |                         |
| 8A. TRADE, PROFESSION OR KIND OF WORK DONE <u>cook</u>  |  |   |  |   |                         |
| 8B. INDUSTRY OR BUSINESS IN WHICH ENGAGED <u>shipping</u>   |  |   |  |   |                         |
| 9. BIRTHPLACE (STATE OR COUNTRY) <u>La.</u>   |  |   |  |   |                         |
| 10. NAME <u>Lawrence Rainwater (dec'd)</u>  |  |   |  |   |                         |
| 11. BIRTHPLACE (STATE OR COUNTRY) <u>Miss</u>   |  |   |  |   |                         |
| 12. MAIDEN NAME <u>Mary Dredden (Dec'd)</u>   |  |   |  |   |                         |
| 13. BIRTHPLACE (STATE OR COUNTRY) <u>La.</u>  |  |   |  |   |                         |
| 14. SIGNATURE <u>Patient</u>  |  |   |  |   |                         |
| ADDRESS <u>1357 San Felipe Cts., Houston, TEXAS</u>   |  |   |  |   |                         |
| 15. PLACE OF BURIAL OR REMOVAL <u>Orange, Texas</u>   |  |   |  |   |                         |
| DATE <u>Apl. 22, 1946</u>   |  |   |  |   |                         |
| 16. SIGNATURE <u>Malloy and Son</u>   |  |   |  |   |                         |
| ADDRESS <u>3028 Ave J, Galveston, TEXAS</u>   |  |   |  |   |                         |
| 20. FILE NUMBER <u>348</u> FILE DATE <u>April 23, 1946</u>  |  |   |  |   |                         |
| SIGNATURE OF LOCAL REGISTRAR <u>Margaret O'Rourke Galveston</u>                                     |  |   |  |   |                         |
| POSTOFFICE ADDRESS <u>Galveston, TEXAS</u>  |  |   |  |   |                         |
| MEDICAL PARTICULARS   |  |   |  |   |                         |
| 18. I HEREBY CERTIFY THAT I ATTENDED THE DECEASED FROM <u>Feb. 5, 1946</u> TO <u>April 22, 1946</u> |  |   |  |   |                         |
| I LAST SAW HIM ALIVE ON <u>April 22, 1946</u>   |  |   |  |   |                         |
| THE DEATH OCCURRED ON THE DATE STATED ABOVE AT <u>2:50 AM</u>                                       |  |   |  |   |                         |
| THE PRIMARY CAUSE OF DEATH WAS:   |  |   |  |   |                         |
| <u>Carcinoma of Pancreas</u>  |  |   |  |   | DURATION <u>unknown</u> |
| CONTRIBUTORY CAUSES WERE <u>Obstruction of duodenum</u>   |  |   |  |   |                         |
|   |  |   |  |   | DURATION <u>2 wks.</u>  |
| IF NOT DUE TO DISEASE, SPECIFY WHETHER: ACCIDENT, SUICIDE, OR HOMICIDE                              |  |   |  |   |                         |
| DATE OF OCCURRENCE  |  |   |  |   |                         |
| PLACE OF OCCURRENCE   |  |   |  |   |                         |
| MANNER OR MEANS   |  |   |  |   |                         |
| IF RELATED TO OCCUPATION OF DECEASED, SPECIFY <u>NO</u>   |  |   |  |   |                         |
| SIGNATURE <u>J. V. COCKRELL, M.D.</u>   |  |   |  |   |                         |
| ADDRESS <u>W. W. NESBITT, MEDICAL DIRECTOR, USPHS, MCG, TEXAS</u>                                   |  |   |  |   |                         |



#1811