

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

PLACE OF DEATH

County Ray Registration District No. 744 File No. 25786
Township Richmond or Rayville Primary Registration District No. 5976 B Registered No. 839
City Rayville (NO. 11) St. 11 Ward 11

(If death occurred in a hospital or institution, give its NAME instead of street and number)

FULL NAME Embarras

PERSONAL AND STATISTICAL PARTICULARS

SEX Male COLOR OR RACE White SINGLE MARRIED WIDOWED OR DIVORCED (Write the word)
DATE OF BIRTH Aug 20, 1919 (Month) (Day) (Year)
AGE 15 yrs. 11 mos. 15 ds. If LESS than 1 day, 3 hrs. or 30 min.?
OCCUPATION (a) Trade, profession, or particular kind of work —
(b) General nature of industry, business, or establishment in which employed (or employer) —

BIRTHPLACE (City or town, State or foreign country) Rayville, Ray co., Mo.

PARENTS
NAME OF FATHER John Proffitt
BIRTHPLACE OF FATHER (City or town, State or foreign country) Ray co., Mo.
MAIDEN NAME OF MOTHER Alpha Gaudin
BIRTHPLACE OF MOTHER (City or town, State or foreign country) Rayville Ray co., Mo.

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE mo
(Informant) John Proffitt
(ADDRESS) Rayville

Filed Aug 21, 1919 Geo W Hunt REGISTRAR
Deputy

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH August 20, 1919 (Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from on Aug. 20, 1919, to —, 191—, that I last saw him alive on Aug. 20, 1919, and that death occurred, on the date stated above, at 5 p.m. The CAUSE OF DEATH was as follows:

premature Birth. Only lived about thirty minutes.

15 (Duration) yrs. 15 mos. ds.

Contributory (SECONDARY) (Duration) yrs. mos. ds.
(Signed) J B Hunt M. D. TA. D.
Aug. 21, 1919 (Address) Rayville, Mo.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of injury; and (2) whether Accidental, Suicidal, or Homicidal.

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.

PLACE OF BURIAL OR REMOVAL Crematory DATE OF BURIAL Aug 21, 1919

UNDERTAKER J. E. B. Hunt ADDRESS Rayville

PLACE OF DEATH

County _____
 Township _____
 or
 Village _____
 or
 City _____

Registration District No. _____

File No. _____

Primary Registration District No. _____

Registered No. _____

(NO. _____)

St. _____

Ward _____

(If death occurred in a
 hospital or institution,
 give its NAME instead
 of street and number)

FULL NAME

PERSONAL AND STATISTICAL PARTICULARS

SEX _____	COLOR OR RACE _____	SINGLE MARRIED WIDOWED OR DIVORCED (Write the word)
DATE OF BIRTH _____	(Month) _____ (Day) _____ (Year) _____	
AGE _____	IF LESS than 1 day, _____ hrs. or _____ min.?	

OCCUPATION

(a) Trade, profession, or particular kind of work _____

(b) General nature of industry, business, or establishment in which employed (or employer) _____

BIRTHPLACE

(City or town, State or foreign country) _____

NAME OF FATHER

BIRTHPLACE OF FATHER

(City or town, State or foreign country) _____

MAIDEN NAME OF MOTHER

BIRTHPLACE OF MOTHER

(City or town, State or foreign country) _____

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) _____

(ADDRESS) _____

Filed _____

191 _____

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH

_____, 191_____, (Month) _____, (Day) _____, 191_____, (Year) _____

I HEREBY CERTIFY, that I attended deceased from _____, 191_____, to _____, 191_____, that I last saw h _____ alive on _____, 191_____, and that death occurred, on the date stated above, at _____ m. The CAUSE OF DEATH* was as follows:

_____, (Duration) _____ yrs. _____ mos. _____ ds.

Contributory
(SECONDARY)

_____, (Duration) _____ yrs. _____ mos. _____ ds.

(Signed) _____

_____, 191_____, (Address) _____ M. D.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

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 _____

PLACE OF BURIAL OR REMOVAL _____

DATE OF BURIAL _____

UNDERTAKER _____

ADDRESS _____