JAN 21 1927

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

Do not use this space.

37838

1. PLACE OF DEATH
County Greene Registration District No. 318 Dr Russell File No.
Township Springfield Mo Primary Registration District No. 7091 Registered No. 845
City (No. St. Johns Hosp St. Ward)

2. FULL NAME Edith Rainwater
(a) Residence. No. Richland Mo St., Ward.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS			MEDICAL CERTIFICATE OF DEATH
3. SEX F	4. COLOR OR RACE W	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) single	16. DATE OF DEATH (MONTH, DAY AND YEAR) 12-28 1926
5a. If Married, Widowed, or Divorced HUSBAND of (or) WIFE of			17. I HEREBY CERTIFY, That I attended deceased from Dec 27, 1926, to Dec 28, 1926 that I last saw h... alive on Dec 27, 1926, and that death occurred, on the date stated above, at 1 a.m.
6. DATE OF BIRTH (MONTH, DAY AND YEAR) Dec 11-1914			THE CAUSE OF DEATH* WAS AS FOLLOWS: Shock due to draining a large post cecal appendical abscess (duration) yrs. 1 mos. 15 ds.
7. AGE Years 12, Months —, Days 17; If LESS than 1 day, ... hrs. or ... min.			CONTRIBUTORY (SECONDARY) Exhaustion (duration) yrs. mos. ds.
8. OCCUPATION OF DECEASED (a) Trade, profession, or particular kind of work (b) General nature of industry, business, or establishment in which employed (or employer) (c) Name of employer			18. WHERE WAS DISEASE CONTRACTED IF NOT AT PLACE OF DEATH? Camden County
9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Mo			DID AN OPERATION PRECEDE DEATH? yes DATE OF Dec 27
PARENTS 10. NAME OF FATHER W E Rainwater			WAS THERE AN AUTOPSY? no
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) Mo			WHAT TEST CONFIRMED DIAGNOSIS? Clinical
12. MAIDEN NAME OF MOTHER Ollie Winfrey			(Signed) C W Russell, M. D
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) Mo			12/28 1926 (Address) 618 Woodruff Bldg
14. INFORMANT W E Rainwater (Address) Richland Mo.			*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. (See reverse side for additional space.)
15. FILED 12-28 1926 Ralph J Brooks REGISTRAR			19. PLACE OF BURIAL, CREMATION, OR REMOVAL Richland Mo; DATE OF BURIAL 12-30 1926
			20. UNDERTAKER R M Lohmeyer ADDRESS. Springfield Mo

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

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH
County Greene Registration District No. 318 File No. 845
Township Primary Registration District No. 2001 Registered No. 845
City Spfg (No. St. Ward)

2. FULL NAME Edith Rainwater

(a) Residence. No. St., Ward. (If nonresident give city or town and State)
(Usual place of abode)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F. 4. COLOR OR RACE W. 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) S.

5a. If Married, Widowed, or Divorced HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR)

7. AGE Years Months Days If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN)
(STATE OR COUNTRY)

PARENTS
10. NAME OF FATHER
11. BIRTHPLACE OF FATHER (CITY OR TOWN)
(STATE OR COUNTRY)
12. MAIDEN NAME OF MOTHER
13. BIRTHPLACE OF MOTHER (CITY OR TOWN)
(STATE OR COUNTRY)

14. INFORMANT
(Address)

15. FILED 12/28 1936 O. C. Horst MD
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Dec 28 1936

17. I HEREBY CERTIFY, That I attended deceased from , 19 , to , 19 , that I last saw h alive on , 19 , and that death occurred, on the date stated above, at m.

THE CAUSE OF DEATH* was as follows:
Shock due to draining a large postcecal appendical abscess. Due to perforated appendix (duration) yrs. mos. ds.
CONTRIBUTORY (SECONDARY) Exhaustion
(duration) yrs. mos. ds.
Not tuberculous not traumatic

18. WHERE WAS DISEASE CONTRACTED IF NOT AT PLACE OF DEATH?
DID AN OPERATION PRECEDE DEATH? DATE OF
WAS THERE AN AUTOPSY?
WHAT TEST CONFIRMED DIAGNOSIS?
(Signed) H.H. G. , M. D.
, 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19. PLACE OF BURIAL, CREMATION, OR REMOVAL | DATE OF BURIAL 19

20. UNDERTAKER | ADDRESS

SUPPLEMENTARY

Left margin: ...should be carefully ... AGE should be stated EXACTLY. PHYSICIANS ... in plain terms, so that it may be properly classified. Exact statement of OCCUPATION ... REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW