

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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**

PLACE OF DEATH

County Waguer Co
Township St. Francois
or
Village _____
or
City _____ (NO. _____)

Registration District No. 890 File No. 22707
Primary Registration District No. 6188 Registered No. _____
St. _____ Ward _____

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

FULL NAME Lilly Arnie Rainwater

PERSONAL AND STATISTICAL PARTICULARS

SEX <u>female</u>	COLOR OR RACE <u>white</u>	SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) <u>single</u>
DATE OF BIRTH <u>Apr 4 1895</u> (Month) (Day) (Year)		
AGE <u>15</u> yrs. <u>3</u> mos. <u>26</u> ds.		IF LESS than 1 day, ___ hrs. or ___ min.?

OCCUPATION
(a) Trade, profession, or particular kind of work School girl
(b) General nature of industry, business, or establishment in which employed (or employer) _____

BIRTHPLACE
(City or town, State or foreign country) Waguer Co Mo

PARENTS

NAME OF FATHER <u>Honolin Rainwater</u>
BIRTHPLACE OF FATHER (City or town, State or foreign country) <u>Waguer Co Mo</u>
MAIDEN NAME OF MOTHER <u>Martha French</u>
BIRTHPLACE OF MOTHER (City or town, State or foreign country) <u>Don't know</u>

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) W. F. Rainwater
(ADDRESS) Germville Mo

Filed July 30 1912 H. G. Wilson
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH July 29 1912
(Month) (Day) (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:
Killed By Lightning
1912

Contributory death Instantaneous
(SECONDARY) (Duration) _____ yrs. _____ mos. _____ ds.
(Signed) _____ M. D.
_____ 191____ (Address) _____

*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 <u>Inchols Cemetery</u>	DATE OF BURIAL <u>July 30 1912</u>
UNDERTAKER <u>H. G. Mabrey</u>	ADDRESS _____