

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 Wayne

Township St-Hammond

or

Village

or

City

(NO.

St.

Ward)

Registration District No. 890

File No. 22708

Primary Registration District No. 6188

Registered No. 26

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

FULL NAME Wilson Lee Rainwater

PERSONAL AND STATISTICAL PARTICULARS

SEX male COLOR OR RACE white SINGLE MARRIED WIDOWED OR DIVORCED (Write the word)

DATE OF BIRTH Oct - 19 1883
(Month) (Day) (Year)

AGE 27 yrs. 3 mos. 11 ds. IF LESS than 1 day, hrs. or min.?

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

BIRTHPLACE (City or town, State or foreign country) Wayne Co

PARENTS NAME OF FATHER William T. Rainwater

BIRTHPLACE OF FATHER (City or town, State or foreign country) Wayne Co Ind

MAIDEN NAME OF MOTHER Maria French

BIRTHPLACE OF MOTHER (City or town, State or foreign country) Don't Know

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

(ADDRESS) Germerville Ind

Filed July 30 1910 L. G. Wilson REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH July 29 1910
(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
1910

Contributory Sudden Instaneous

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

(Signed) _____ M. D.

(Address) _____, 191____

*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 Nichols Cemetery DATE OF BURIAL July 30 1910

UNDERTAKER A. G. Mabrey ADDRESS _____