

1. PLACE OF DEATH a. COUNTY Wilbarger		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Texas b. COUNTY Wilbarger	
b. CITY OR TOWN (If outside city limits, give precinct no.) Vernon		c. LENGTH OF STAY in l. b. 43 yrs	
d. NAME OF (If not in hospital, give street address) HOSPITAL OR INSTITUTION Wilbarger General		e. IS RESIDENCE INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		4. DATE OF DEATH 11-8-72	
3. NAME OF DECEASED (Type or print) Roscoe		(a) First (b) Middle (c) Last Rainwater	
5. SEX Male	6. COLOR OR RACE White	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 7-4-1883
9. AGE (In years last birthday) 89		IF UNDER 1 YEAR Months Days Hours Minutes	IF UNDER 24 HRS. Hours Minutes
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Insurance		10b. KIND OF BUSINESS OR INDUSTRY Insurance	
11. BIRTHPLACE (State or foreign country) Kentucky		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Josiah W. Rainwater		14. MOTHER'S MAIDEN NAME Elizabeth J. Weddle	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 460 36 2196	
17. INFORMANT Johnnie Rainwater		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) HEPATIC IMMEDIATE CAUSE (a) Hepatic which gave rise to above cause (a), stating the underlying condition (b) Probable Trauma Hepatic BUREAU OF VITAL STATISTICS DUE TO (c) Hepatic	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Pat of Ca Colon No evidence of recurrence		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Hour a.m. p.m. Month Day Year		20d. INJURY OCCURRED	
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office building, etc.)		20f. CITY, TOWN, OR LOCATION COUNTY STATE	
21. I hereby certify that I attended the deceased from 1968 to 11-8 , 19 72 and last saw the deceased alive on 11-8-72 , 19 72 . Death occurred at 12:30 p.m. on the date stated above, and to the best of my knowledge, from the causes stated.		22a. SIGNATURE [Signature] (Degree or title) MD	
22b. ADDRESS Vernon, Texas		22c. DATE SIGNED 11-16-72	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 11-10-72	
23c. LOCATION (City, town, or county) Vernon, Texas		23d. NAME OF CEMETERY OR CREMATORY Wilbarger Memorial Park	
24. FUNERAL DIRECTOR'S SIGNATURE [Signature]		25. REGISTRAR'S SIGNATURE [Signature]	
25a. REGISTRAR'S FILE NO.		25b. DATE REC'D BY LOCAL REGISTRAR NOV 16 1972	

TEXAS DEPARTMENT OF HEALTH — BUREAU OF VITAL STATISTICS

MEDICAL CERTIFICATION