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

Do not use this space.

1. PLACE OF DEATH
County St Francois — Registration District No. 794
Township St Francois — Primary Registration District No. 60-1819
City Flat River — (No. ..... St. ..... Ward) — File No. 84 38204
Registered No. .....

2. FULL NAME John M. Rebadaux
(a) Residence. No. ..... 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

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)
M	White	Married

5A. IF MARRIED, WIDOWED, OR DIVORCED
HUSBAND OF (OR) WIFE OF Anna Rebadaux

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Feb 6 - 1849

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ...hrs. or ....min.
	80	10	2	

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

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

PARENTS
10. NAME OF FATHER John Rebadaux
11. BIRTHPLACE OF FATHER (CITY OR TOWN) .....
(STATE OR COUNTRY) France
12. MAIDEN NAME OF MOTHER Mary Lachance
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) .....
(STATE OR COUNTRY) France

14. INFORMANT Mrs. Anna Rebadaux
(Address) Flat River Mo.

15. FILED Nov 29 29 W J Bryan REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 11-8-1929

17. I HEREBY CERTIFY, That I attended deceased from 10-22-29 to 11-8-29 that I last saw h. alive on 11-4-29, and that death occurred, on the date stated above, at 9:40 A. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Acute Colitis
(duration) ..... yrs. 15 mos. ..... ds.
CONTRIBUTORY (SECONDARY) Hemiplegia
(duration) 3 yrs. ..... mos. ..... ds.

18. WHERE WAS DISEASE CONTRACTED? P.K.
IF NOT AT PLACE OF DEATH .....
DID AN OPERATION PRECEDE DEATH? No DATE OF .....
WAS THERE AN AUTOPSY? No
WHAT TEST CONFIRMED DIAGNOSIS? Clinical
(Signed) W. J. Bryan M. D.
(Address) Flat River

*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.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL	DATE OF BURIAL
Mo. Bismarck Mo.	11/10 1929
20. UNDERTAKER	ADDRESS
Raymond Caldwell	Flat River Mo.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. AGE should be stated EXACTLY. PHYSICIANS should state carefully supplied.