

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

Do not use this space.

✓  
29455

**1. PLACE OF DEATH**

County Stoddard  
Township Castor  
City (No. ....) .....

Registration District No. 837  
Primary Registration District No. 6099

File No. ....  
Registered No. ....  
St. .... Ward)

**2. FULL NAME**

Samuel Raustink

(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. da. How long in U.S., if of foreign birth? yrs. mos. da.

**PERSONAL AND STATISTICAL PARTICULARS**

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

M W married

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

H

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

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, .... hrs. or .... min.

76 2 8

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Farmer  
(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) State of Illu

10. NAME OF FATHER

Not known

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY) Not known

12. MAIDEN NAME OF MOTHER

Not known

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY) Not known

PARENTS

14. INFORMANT Walter Raustink  
(Address) Box R #2

15. FILED 9-5 1928 Edward Ford  
REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

2

16. DATE OF DEATH (MONTH, DAY AND YEAR) 8-26 1928

17. I HEREBY CERTIFY, That I attended deceased from Aug 1st 1928 to Aug 26 1928 that I last saw him alive on Aug 1st 1928, and that death occurred, on the date stated above, 7 am m.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:

Cardiac crapsy  
92A 900  
95B 900 (duration) 6 yrs. 6 mos. 6 da.

CONTRIBUTORY chronic endocarditis (SECONDARY) (duration) 2 yrs. .... mos. .... da.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH? .....

19. DID AN OPERATION PRECEDE DEATH? No. DATE OF .....

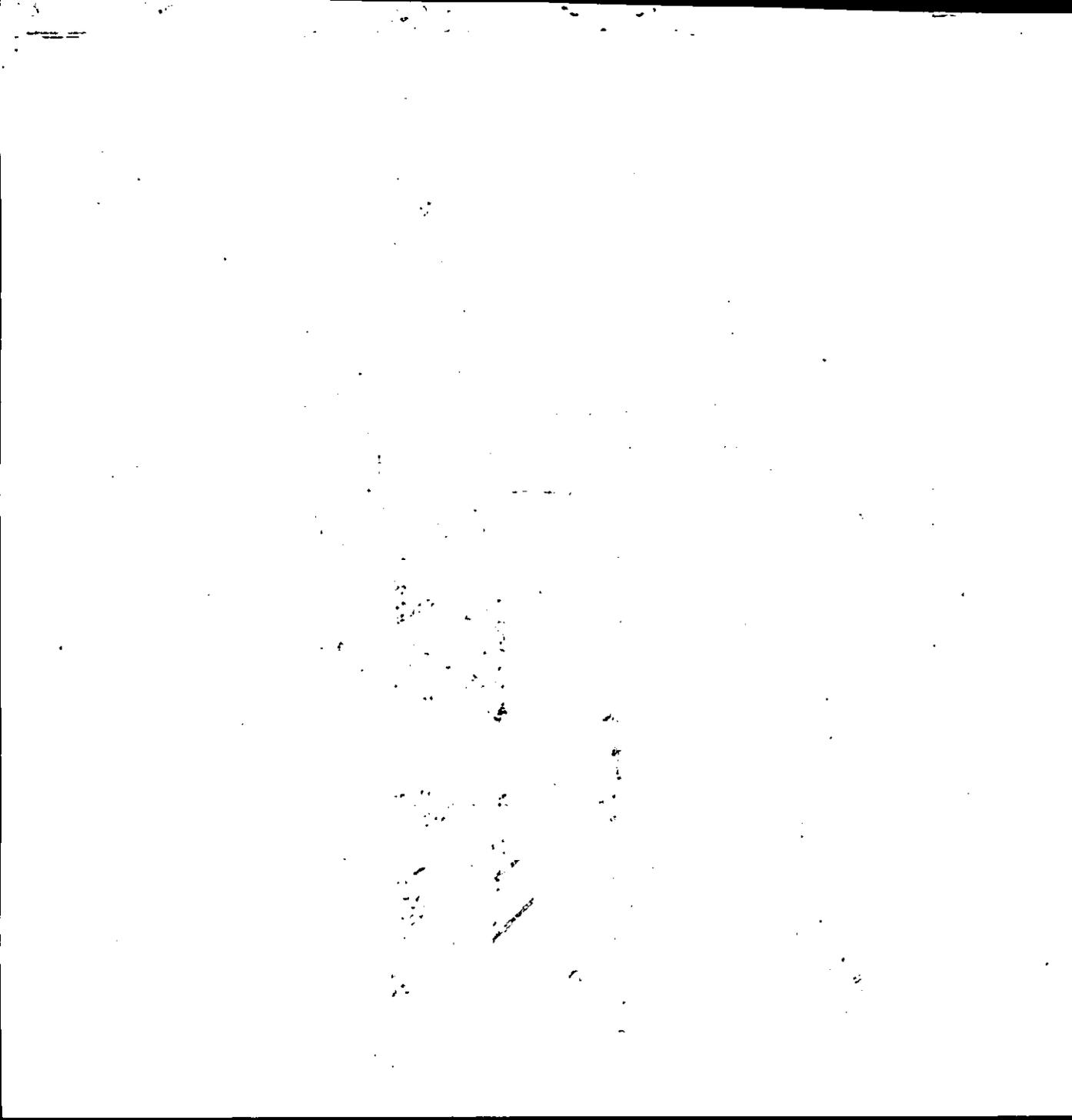
WAS THERE AN AUTOPSY? No

WHAT TEST CONFIRMED DIAGNOSIS? General  
(Signed) D. J. Davis, M. D.  
, 19 - (Address) Bloomfield

\*State the DISEASE CAUSING DEATH, or in death from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Bloomfield Cem DATE OF BURIAL 8-27 1928

20. UNDERTAKER J. A. Childs Bloomfield  
ADDRESS



**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 Stoddard Registration District No. 837 File No. \_\_\_\_\_  
 Township Easton Primary Registration District No. 6099 Registered No. \_\_\_\_\_  
 City \_\_\_\_\_ (No. \_\_\_\_\_) St. \_\_\_\_\_ Ward \_\_\_\_\_

2. FULL NAME Samuel Rankins  
 (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 M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) M

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.
	<u>76</u>	<u>2</u>	<u>8</u>	

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) State of Ohio

10. NAME OF FATHER Not known

11. BIRTHPLACE OF FATHER (CITY OR TOWN) \_\_\_\_\_  
 (STATE OR COUNTRY) Not known

12. MAIDEN NAME OF MOTHER Not known

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) \_\_\_\_\_  
 (STATE OR COUNTRY) Not known

14. INFORMANT Walter Rankins  
 (Address) Cesey, No R# 2

15. FILED 9-5-29 Edward Ford  
 REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) 8-26-28

17. I HEREBY CERTIFY That I attended deceased from Aug 1st, 1928, to Aug 26, 1928  
 that I last saw him alive on Aug 1st, 1928 and that death occurred, on the date stated above, at \_\_\_\_\_ a.m.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:  
Cardiac drapes

CONTRIBUTORY (SECONDARY) \_\_\_\_\_  
 (duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

18. WHERE WAS DISEASE CONTRACTED \_\_\_\_\_  
 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) S.S. Davis, M. D.  
 , 19 (Address) Bloomfield

\*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 Bloomfield DATE OF BURIAL 8-27-28  
 20. UNDERTAKER J.A. Chiles ADDRESS Bloomfield

THIS FORM SHALL NOT RECEIVE A FEE FOR... STATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

SUPPLEMENTARY

5-29453