

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.

1580 MAY 19 1939

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

14922
Do not use this space.

1. PLACE OF DEATH
 (a) County GREENE Registration District No. 317
 (b) Township Brookline Primary Registration District No. 5441
 (c) City or ~~or~~ SPRINGFIELD (d) Street No. _____ St.
 (e) Length of residence in city or town where death occurred (If death occurred in Hospital or Institution, write its name instead of street and number) yrs. mos. da. (f) How long in U. S., if of foreign birth? yrs. mos. da.

2. PRINT FULL NAME
 (a) Residence, No. 545 Mrs Emma Rankin
Box 2 Republic Mo (Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (Use the word Widowed)
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Chas. G. Rankin
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Feb 28, 1853
 7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min. 86 1 23
 OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. housewife
 9. Industry or business in which work was done, as saw mill, bank, etc. _____
 10. Date deceased last worked at this occupation (month and year) _____ 11. Total time (years) spent in this occupation _____
 12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) New York City
 FATHER 13. NAME Arthur
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Holland
 MOTHER 15. MAIDEN NAME Grace
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) _____
 17. INFORMANT Mrs Anna Rankin
 (ADDRESS) Box 2 Republic Mo
 18. BURIAL, CREMATION, OR REMOVAL PLACE Maple Hill DATE April 18, 1939
 19. FUNERAL DIRECTOR (NAME) (ADDRESS) W. H. Schaefer
Springfield Mo
 20. FILED May 6, 1939 Bertha Nance
 Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) April 16, 1939
 22. I HEREBY CERTIFY, That I attended deceased from Dec 5, 1938 to April 16, 1939
 I last saw him alive on 4-16-39. Death is said to have occurred on the date stated above, at 11:48 a.m.
 The principal cause of death and related causes of importance were as follows:
Cerebral Hemorrhage
Hypertension
 Other contributory causes of importance: gout
 Name of operation _____ Date of _____
 What test confirmed diagnosis? biopsy Was there an autopsy? _____
 23. If death was due to external causes (violence), fill in also the following:
 Accident, suicide, or homicide? _____ Date of injury _____, 19____
 Where did injury occur? _____ (Specify city or town, county, and State)
 Specify whether injury occurred in industry, in home, or in public place. _____
 Manner of injury _____
 Nature of injury _____
 24. Was disease or injury in any way related to occupation of deceased? _____
 If so, specify _____
 (Signed) Robert C. Mitchell M. D.
Republic Mo (Address)

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....
....., Registered Apprentice No.....
working under my personal supervision.

Signed.....

Licensed Embalmer No.....

P. O. Address.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.