

Registration District No. 43

Primary Registration District No. 3007

State File No. _____

Registrar's No. 263

1. PLACE OF DEATH:

(a) County Butter
 (b) City or town Poplar Bluff
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution 1105 Garfield
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 4 mo.
(Specify whether years, months or days)

3. (a) PRINT FULL NAME Baby Cordell Rankins

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex Female 5. Color or race Cobred 5. (a) Single, widowed, married, divorced S. O

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased Apr. 8, 1943
(Month) (Day) (Year)

8. AGE: Years _____ Months 4 Days 14 If less than one day _____ hr. _____ min.

9. Birthplace Poplar Bluff, Mo.
(City, town, or county) (State or foreign country)

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER

12. Name Milton Rankins

13. Birthplace Tupelo, Ark.
(City, town, or county) (State or foreign country)

14. Maiden name Flora Rankins

15. Birthplace Cotton Plant, Ark.
(City, town, or county) (State or foreign country)

16. (a) Informant Flora Rankins

(b) Address B. Poplar Bluff, Mo.

17. (a) B. (Burial, cremation, or removal) (b) Date thereof 8-23-43
(Month) (Day) (Year)

(c) Place: burial or cremation City - Poplar Bluff, Mo.

18. (a) Signature of funeral director Frank Cotrell

(b) Address Poplar Bluff, Mo.

19. (a) 8-28-43 (Data received local registrar) (b) Steve Kinne (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Butter
 (c) City or town Poplar Bluff
(If outside city or town limits, write "RURAL")
 (d) Street No. 1105 Garfield
(If rural, give location)
 (e) Citizen of foreign country? _____ (Yes or No)
 If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug day 22 year 1943 hour 11:25 minute _____ P. M.

21. I hereby certify that I attended the deceased from 8-21 to 8-22 that I last saw alive and that death occurred on the date and hour stated above.

Immediate cause of death Broncho - Pneumonia Duration _____

Due to _____

Due to _____

Other conditions (Include pregnancy within 3 months of death) _____

Major findings: Of operations _____

Of autopsy _____

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____
 (b) Date of occurrence _____
 (c) Where did injury occur? _____ (City or town) (County) (State)
 (d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work? _____ (Specify type of place) (e) Means of injury _____

23. Signature Steve Kinne (M. D. or other) _____

Address Poplar Bluff, Mo. Date signed _____

RECEIVED

District Health Office No. 2

District File Number 943-182

Date Filed 4-13-13

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 Scott A. Bobitt

Licensed Embalmer No. 2567

P. O. Address Poplar Bluff, Mo.

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

If this body is not embalmed, fact should be so stated above.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. _____
Registrar's No. 263

Registration District No. 4.3 Primary Registration District No. 2007

1. PLACE OF DEATH:
(a) County Butler
(b) City or town Paris, Mo.
(c) Name of hospital or institution:

(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution. _____ (Specify whether
In this community, _____ years, months or days) (Specify whether

3. (a) PRINT FULL NAME Cordell Rankins
3. (b) If veteran, name war. _____ 3. (c) Social Security No. _____

4. Sex M 5. Color or race B 6. (a) Single, widowed, married, divorced S
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased Apr (Month) 1 (Day) 1943 (Year)

8. AGE: Years _____ Months 4 Days _____ If less than one day _____ min.
9. Birthplace _____ (City, town, or county) _____ (State or foreign country)

10. Usual occupation _____
11. Industry or business _____
12. Name _____
13. Birthplace _____ (City, town, or county) _____ (State or foreign country)
14. Maiden name _____
15. Birthplace _____ (City, town, or county) _____ (State or foreign country)

16. (a) Informant _____ (b) Address _____
17. (a) _____ (b) Date thereof _____ (Month) (Day) (Year)
(c) Place: burial or cremation _____
18. (a) Signature of funeral director _____ (b) Address _____
19. (a) _____ (b) _____ (Registrar's signature)
(Date received local registrar)

2. USUAL RESIDENCE OF DECEASED:
(a) State _____ (b) County _____
(c) City or town _____ (If outside city or town limits, write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month _____ year 1943 hour _____ minute _____ M.
21. I hereby certify that I attended the deceased from _____ 19____; that I last saw him _____ after he on _____ 19____; and that death occurred on the date and hour stated above. Immediate cause of death Branchio pneumonia

Due to Whooping cough Duration _____
Due to _____
Other conditions (Include pregnancy within 3 months of death) _____
Major findings: Of operations _____
Of autopsy _____

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) _____
(b) Date of occurrence _____
(c) Where did injury occur? _____ (City or town) _____ (County) _____ (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?
While at work? _____ (Specify type of place) (e) Means of injury _____
23. Signature Wm Rankins (M. D. or other) _____
Address Paris, Mo. Date signed _____

SUPPLEMENTARY

MOTHER FATHER

PHYSICIAN
Underline the cause to which death should be charged statistically.

27811