

FILED MAY 21 1954

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

17617

State File No. _____

BIRTH NO. _____ REG. DIST. NO. 333 PRIMARY REG. DIST. NO. 3074 Registrar's No. 61

| | | | |
|--------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------|--|
| 1. PLACE OF DEATH a. COUNTY <u>Scott</u> | | 2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Scott</u> | |
| b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Sikeston, Mo</u> | | c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Sikeston, Mo</u> | |
| c. LENGTH OF STAY (in this place) <u>Life</u> | | d. STREET ADDRESS (If rural, give location) <u>312 N Ranney Sikeston, Mo</u> | |
| d. FULL NAME OF HOSPITAL OR INSTITUTION <u>312 N. Ranney</u> | | | |

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|-------------------------------------|-------------------------|-------------------------|-------------------------|-------------------------------------------------------|
| 3. NAME OF DECEASED (Type or Print) | a. (First) <u>David</u> | b. (Middle) <u>Paul</u> | c. (Last) <u>Rankin</u> | 4. DATE OF DEATH (Month) (Day) (Year) <u>5 2 1954</u> |
|-------------------------------------|-------------------------|-------------------------|-------------------------|-------------------------------------------------------|

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|-----------------|---------------------------|-----------------------------------------------------------------|---------------------------------|-------------------------------------------|------------------------------------------------|----------------------------------------------|
| 5. SEX <u>M</u> | 6. COLOR OR RACE <u>W</u> | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>M</u> | 8. DATE OF BIRTH <u>7/12/06</u> | 9. AGE (in years last birthday) <u>47</u> | IF UNDER 1 YEAR Months <u>9</u> Days <u>23</u> | IF UNDER 24 HRS. Hours <u></u> Mins. <u></u> |
|-----------------|---------------------------|-----------------------------------------------------------------|---------------------------------|-------------------------------------------|------------------------------------------------|----------------------------------------------|

| | | | |
|---------------------------------------------------------------------------------------------------------------------|-----------------------------------|--------------------------------------------------------------------|--------------------------------------------|
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Funeral Director</u> | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (City and State or Foreign Country) <u>Missouri</u> | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> |
|---------------------------------------------------------------------------------------------------------------------|-----------------------------------|--------------------------------------------------------------------|--------------------------------------------|

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|-------------------------------------------|------------------------------------------------|---------------------------------------------------|
| 13a. FATHER'S NAME <u>Franklin Rankin</u> | 13b. MOTHER'S MAIDEN NAME <u>Madie Unknown</u> | 14. NAME OF HUSBAND OR WIFE <u>Pauline Rankin</u> |
|-------------------------------------------|------------------------------------------------|---------------------------------------------------|

| | | | |
|--------------------------------------------------------------------------------------------------------------------|--------------------------------------------|----------------------------------------------------------------------|---------|
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u> | 16. SOCIAL SECURITY NO. <u>498-10-5626</u> | 17. INFORMANT'S SIGNATURE OR NAME <u>Pauline Rankin Sikeston, Mo</u> | ADDRESS |
|--------------------------------------------------------------------------------------------------------------------|--------------------------------------------|----------------------------------------------------------------------|---------|

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|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------|
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death. | I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Acute Coronary Insufficiency</u> | | INTERVAL BETWEEN ONSET AND DEATH <u>5. MID</u> <u>3 years</u> |
| | ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Hypertensive Cardiovascular Disease</u> | | |
| | DUE TO (c) | | |
| II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. | | | |

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|------------------------|----------------------------------|----------------------------------------------------------------------------------|
| 19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
|------------------------|----------------------------------|----------------------------------------------------------------------------------|

| | | |
|------------------------------------------|------------------------------------------------------------------------------------------|-------------------------------------------------|
| 21a. ACCIDENT SUICIDE HOMICIDE (Specify) | 21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) |
|------------------------------------------|------------------------------------------------------------------------------------------|-------------------------------------------------|

| | | |
|-------------------------------------------------|--------------------------------------------------------------------------------------------------------|---------------------------|
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | 21f. HOW DID INJURY OCCUR |
|-------------------------------------------------|--------------------------------------------------------------------------------------------------------|---------------------------|

22. I hereby certify that I attended the deceased from 5-2, 1954, to _____, 19____, that I last saw the deceased alive on 4-29, 1954, and that death occurred at 30P m., from the causes and on the date stated above.

| | | |
|-------------------------------------------------------------|---------------------------------|--------------------------------|
| 23a. SIGNATURE (Degree or title) <u>Andra B. Smith M.D.</u> | 23b. ADDRESS <u>Sikeston Mo</u> | 23c. DATE SIGNED <u>5-7-54</u> |
|-------------------------------------------------------------|---------------------------------|--------------------------------|

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|---------------------------------------------------------|-------------------------|-------------------------------------------------------------|------------------------------------------------------------------|
| 24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | 24b. DATE <u>5/4/54</u> | 24c. NAME OF CEMETERY OR CREMATORY <u>Memorial Park Cem</u> | 24d. LOCATION (City, town, or county) (State) <u>Sikeston Mo</u> |
|---------------------------------------------------------|-------------------------|-------------------------------------------------------------|------------------------------------------------------------------|

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|-----------------------------------------|----------------------------------------------------|-------------------------------------------------|---------|
| DATE REC'D BY LOCAL REG. <u>5-12-54</u> | REGISTRAR'S SIGNATURE <u>Mrs. Elizabeth Hunter</u> | EMERALD DIRECTOR'S SIGNATURE <u>Harry Jones</u> | ADDRESS |
|-----------------------------------------|----------------------------------------------------|-------------------------------------------------|---------|

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

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1005
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4201

DATE RECEIVED MAY 17 1954
SCOTT CO. HEALTH DEPT.
CO. FILE No. 554-987

FEB 7 1954

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 _____

Student Embalmer No. _____

working under my personal supervision.

Student
Student Embalmer

Signed John Alleton

Licensed Embalmer No. 2941

P. O. Address St. Louis

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, fact should be so stated above.