LOCAL REGISTRAR'S RECORD—DO NOT TEAR LEAF OUT

JUN 2 3 1926

11214 a

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

1 PLACE OF DEATH

County Sullivan

Township Penn or Village or City Green Castle Mo (NO. ..... St.: ..... Ward)

Registration District No. 848 File No. X 1

Primary Registration District No. 4514 Registered No. X 1

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Mrs Sarah Belle Rankin

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female

4 COLOR OR RACE White

5 ~~SINGLE~~ MARRIED ~~WIDOWED~~ ~~OR DIVORCED~~ (Write the word) Married

6 DATE OF BIRTH Nov - 3, 1857 (Month) (Day) (Year)

7 AGE 68 yrs. 4 mos. 17 ds. If LESS than 1 day, ... hrs. or ..... min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry business, or establishment in which employed (or employer) House work

9 BIRTHPLACE (City or town, State or foreign country) Illinois

PARENTS

10 NAME OF FATHER Wiley Moss

11 BIRTHPLACE OF FATHER (City or town, State or foreign country) Don't Know

12 MAIDEN NAME OF MOTHER Don't Know

13 BIRTHPLACE OF MOTHER (City or town, State or foreign country) Don't Know

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Charley Rankin
(Address) Green Castle Mo.

15 Filed 6-9-1926 Wm Parsons Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH March (Month) 21 (Day), 1926 (Year)

17 I HEREBY CERTIFY, that I attended deceased from Mar 19, 1926, to Mar 20, 1926, that I last saw her alive on March 20, 1926, and that death occurred, on the date stated above, at 10-a m.

The CAUSE OF DEATH* was as follows:
Paralysis
Hemiplegia
75 A
(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) W. L. Taylor M. D.
..... 191..... (Address) Green Castle Mo

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)
At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19 PLACE OF BURIAL OR REMOVAL Green Castle Mo DATE OF BURIAL Mch. 23, 1926

20 UNDERTAKER Glenn E. Kent ADDRESS Green City Mo

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.

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

LOCAL REGISTRAR'S RECORD—DO NOT TEAR LEAF OUT

MISSOURI STATE BO
BUREAU OF VITAL
CERTIFICATE O

Revised United States Standard Certificate of Death

(Approved by U. S. Census and American Public Health Association.)

1 PLACE OF DEATH

County .....

Township ..... Registration District No. ..... File No. .....
or
Village ..... Primary Registration District No. ..... Registered No. .....
or
City ..... (NO. ....., ... St., ... Ward)

2 FULL NAME .....

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 SINGLE MARRIED WIDOWED OR DIVORCED (*Write the word*)

6 DATE OF BIRTH

..... (Month) ....., 1..... (Day) (Year)

7 AGE

..... yrs. ..... mos. ..... ds.

If LESS than 1 day, ... hrs. or ..... min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work .....
(b) General nature of industry business, or establishment in which employed (or employer) .....

9 BIRTHPLACE (City or town, State or foreign country)

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (City or town, State or foreign country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (City or town, State or foreign country)

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) .....

(Address) .....

15

Filed ....., 191....., ...
Registrar

MEDICAL CERTIFICATE O

16 DATE OF DEATH

..... (Month)

17 I HEREBY CERTIFY, that I

....., 191....., to .....

that I last saw h..... alive on .....

and that death occurred, on the date statec

The CAUSE OF DEATH* was as follows:

..... (Duration) ..... yrs.

CONTRIBUTORY (Secondary) .....

..... (Duration) ..... yrs.

(Signed) .....

....., 191..... (Address) .....

*State the Disease Causing Death, or, in deaths from (1) Means of Injury; and (2) whether Accidental, S

18 LENGTH OF RESIDENCE (For Hospitals, Inst or Recent Residents)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yr

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL OR REMOVAL

DAT

20 UNDERTAKER

ADDI

Statement of Occupation

"Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc.; of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor"