

FILED JAN 30 1943
Registration District No. 2000

Primary Registration District No. 2000

State File No. _____

Registrar's No. 28

1. PLACE OF DEATH:
(a) County GREENE
(b) City or town Springfield
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
O'Reilly General Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 16 days
In this community 16 days
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Minnesota (b) County St. Louis 999
(c) City or town Markham 21
(If outside city or town limits, write "RURAL")
(d) Street No. Rte. #1
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country _____ 2

3. (a) PRINT FULL NAME EMIL E. RANTA
3. (b) If veteran, name war None
3. (c) Social Security No. Unknown

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month January day 10
year 1943 hour 5 minute 45 A.M.

4. Sex Male 5. Color or race White
6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Lillian Ranta
6. (c) Age of husband or wife if alive Unknown years
7. Birth date of deceased April 10, 1908
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from December 26, 1942 to January 10, 1943
that I last saw him alive on January 9, 1943
and that death occurred on the date and hour stated above.
Immediate cause of death Edema, post-operative, of cerebellum Duration 12 days

8. AGE: Years 34 Months 9 Days 0
If less than one day hr. _____ min. _____

Due to Hydrocephalus, acquired, internal ?
Due to Arachnoiditis ?
Other conditions _____
(Include pregnancy within 3 months of death)

9. Birthplace Markham Minnesota
(City, town, or county) (State or foreign country)
10. Usual occupation Mining

PHYSICIAN
Major findings: Confirmation of above diagnoses.
Of operations _____
Of autopsy _____
Underline the cause to which death should be charged statistically.

MOTHER FATHER
11. Industry or business _____
12. Name Hemming Ranta (deceased)
13. Birthplace Markham Minnesota
(City, town, or county) (State or foreign country)
14. Maiden name Allina Kangas
15. Birthplace Wasa Finland
(City, town, or county) (State or foreign country)

16. (a) Informant Hayno Ranta (brother)
(b) Address Rte. 1, Box 80, Aurora, Minn.
17. (a) Removal (b) Date thereof Jan. 11, 1943
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Virginia, Minnesota
18. (a) Signature of funeral director [Signature]
(b) Address Springfield, Mo.
19. (a) 1-11-43 (b) [Signature]
(Date received local registrar) (Registrar's signature)

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 Stephen A. Ellis L.T.M.C.
Address O'Reilly General Hospital Date signed Jan 10, 1943

484

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

OCT 20 1949

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..... *E. O. Hestley*.....

Licensed Embalmer No. *1767*.....

P. O. Address. *Spuy. Field*.....

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.

X

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 228/

Registration District No. 128

Primary Registration District No. 2000

Registrar's No. 28

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

1. PLACE OF DEATH:

(a) County Greene
(b) City or town Springfield
(If outside city or town limits, write "RURAL" and name of township)
(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

3. (a) PRINT FULL NAME Emil E. Ranta

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

4. Sex m 5. Color or race W 6. (a) Single, widowed, married, divorced m
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if _____
immediate cause of death _____ years
7. Birth date of deceased April 10
(Month) (Day) (Year)

8. AGE: Years 34 Months _____ Days _____ If less than one day _____ min.

9. Birthplace _____ (City, town, or county) (State or foreign country) mun

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 _____
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (b) _____
(Date received local registrar) (Registrar's signature)

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 Jan Day 10 Year 1943 Hour _____ Minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____; that I saw him _____, 19____; and that death occurred on the date and hour stated above.

Immediate cause of death Edema of cerebellum
of peripheral of cerebellum 124

Due to Hydrocephalus, acquired
internal
Due to arachnoiditis

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

Major findings: Of operations Small area of chronic
arachnoiditis blocking foramen
Of autopsy of mouse
same

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)
(b) Did injury occur in or about home, on farm, in industrial place, in public place? _____

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

23. Signature A. Stephen Willis (M. D. or other) MD
Address 101 N. 7th St. M.C. Date signed 3-1-43

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