

## STANDARD CERTIFICATE OF DEATH

24467

State File No.

Registration District No.

Primary Registration District No.

Registrar's No.

## 1. PLACE OF DEATH:

(a) County Nodaway  
 (b) City or town Maryville  
 (If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution: St. Francis Hospt'  
 (If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution 5 weeks  
 (Specify whether years, months or days)

3. (a) PRINT FULL NAME MYRTLE ALMA RANKIN

3. (b) If veteran, name war \*\*\*  
 3. (c) Social Security No. none

4. Sex female 5. Color or race \_\_\_\_\_  
 6. (a) Single, widowed, married, divorced mar  
 6. (b) Name of husband or wife John A. Rankin Jr.  
 6. (c) Age of husband or wife if alive 78 years  
 7. Birth date of deceased March 11 1870  
 (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
76 2 24 hr. \_\_\_\_\_ min.

9. Birthplace Gerlow Illinois  
 (City, town, or county) (State or foreign country)

10. Usual occupation at home

11. Industry or business \_\_\_\_\_

MOTHER FATHER { 12. Name Henry Sigafoo  
 13. Birthplace New York  
 (City, town, or county) (State or foreign country)  
 14. Maiden name Flora Shaw  
 15. Birthplace unknown  
 (City, town, or county) (State or foreign country)

16. (a) Informant Irene Rankin  
 (b) Address Tarkio, Mo.

17. (a) burial (b) Date thereof 6/7/46  
 (Burial, cremation, or removal) (Month) (Day) (Year)  
 (c) Place: burial or cremation Tarkio Home Cemetery

18. (a) Signature of funeral director Davis Funeral Home  
 (b) Address Tarkio, Mo.

19. (a) 6-11-46 (b) H. M. Hall  
 (Date received local registrar) (Registrar's signature)

## 2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Atchison  
 (c) City or town Tarkio  
 (If outside city or town limits, write "RURAL")  
 (d) Street No. \_\_\_\_\_ (If rural, give location)  
 (e) Citizen of foreign country? no (Yes or No)  
 If yes, name country \_\_\_\_\_

## MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 5th.  
 year 1946 hour 11 minute 30 p. M.  
 21. I hereby certify that I attended the deceased from May 4 - 1946  
 \_\_\_\_\_, 19\_\_\_\_, to June 5, 1946  
 that I last saw h. er alive on June 5, 1946  
 and that death occurred on the day and hour stated above.

Immediate cause of death Myocardial Degeneration  
 Duration \_\_\_\_\_  
 Due to Fracture of left humerus  
 Due to \_\_\_\_\_

Other conditions \_\_\_\_\_  
 (Include pregnancy within 3 months of death)

Major findings: Of operations \_\_\_\_\_  
 Of autopsy \_\_\_\_\_  
 ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED  
 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) accident 3  
 (b) Date of occurrence May 4 - 1946  
 (c) Where did injury occur? Tarkio Mo  
 (City or town) (County) (State)  
 (d) Did injury occur in or about home, on farm, in industrial place, in public place?  
near her home  
 While at work? \_\_\_\_\_ (Specify type of place) (e) Means of injury accident  
 23. Signature H. M. Hall (M. D. or other)  
 Address Maryville, Mo. Date signed 6-8-46

---

---

**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..... **2394**

P. O. Address..... **Tarkio, Mo.**

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

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

Registration District No. 251

Primary Registration District No. \_\_\_\_\_

Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH:

(a) County nodaway  
(b) City or town marysville  
(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

Myrtle A. Rankin

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

4. Sex F 5. Color or race \_\_\_\_\_ 6. (a) Single, widowed, married, divorced m

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

7. Birth date of deceased mar 11  
(Month) (Day) (Year)

8. AGE: Years 76 Months 2 Days \_\_\_\_\_ (Unless than one day)  
hr. \_\_\_\_\_ min.

9. Birthplace \_\_\_\_\_ (City, town, or county) (State or foreign country) Ill

10. Usual occupation \_\_\_\_\_

11. Industry or business \_\_\_\_\_

12. Name \_\_\_\_\_

13. Birthplace \_\_\_\_\_ (City, town, or county) (State or foreign country)

14. Maiden name \_\_\_\_\_ (City, town, or county) (State or foreign country)

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 July  
year 1946 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_ to \_\_\_\_\_, 19\_\_\_\_;

that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_;

and that death occurred on the date and hour stated above.  
Immediate cause of death \_\_\_\_\_

Duration \_\_\_\_\_

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_ (Include pregnancy within 3 months of death)

Major findings: Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

**ADDITIONAL SUPPLEMENTARY PHYSICIAN INFORMATION REQUIRED**

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? no (Specify type of place) \_\_\_\_\_ (e) Means of injury at home fall

23. Signature M. M. Hallis (M. D. or other) \_\_\_\_\_

Address Marysville Mo Date signed 8-2-46

**SUPPLEMENTARY**

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

23316

24407