

No. 2
1-5-43
5-17-39
1 X 56671

FILED JUL 26 1947

State File No. _____

Registration District No. ~~352~~ 352

Primary Registration District No. 6191

Registrar's No. ~~16~~ 16

1. PLACE OF DEATH:

(a) County Janey CO

(b) City or town Rural Jasper Twp
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
Home
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____ (Specify whether _____)

In this community 7 months
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State MO (b) County Janey 106

(c) City or town Rural Jasper Twp
(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 _____

3. (a) PRINT FULL NAME JACOB RANTZ

3. (b) If veteran, name war none

3. (c) Social Security No. none

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 6 day 8
year 1947 hour 4 minute 25 P M.

21. I hereby certify that I attended the deceased from 10-17, 193, to 6-8, 1947,
that I last saw him alive on 6-8, 1947,
and that death occurred on the date and hour stated above.

Immediate cause of death _____ Duration _____

4. Sex male 5. Color or race white

6. (a) Single, widowed, married, divorced widowed

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

7. Birth date of deceased. 5 7 1858
(Month) (Day) (Year)

Due to Vascular Emphysema
paralysis of
myocardium

Due to Cerebral Hemorrhage
arteriosclerosis

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.

8. AGE: Years 89 Months 1 Days 1
If less than one day _____ hr. _____ min.

9. Birthplace Wabash Co Ind
(City, town, or county) (State or foreign country)

10. Usual occupation Farmer

11. Industry or business _____

MOTHER FATHER { 12. Name DANIEL RANTZ

13. Birthplace Wabash Co Ind
(City, town, or county) (State or foreign country)

14. Maiden name CHRISTINE CARNES

15. Birthplace Wabash Co Ind
(City, town, or county) (State or foreign country)

16. (a) Informant Jim Rantz

(b) Address Reeds Spring Mo

17. (a) burial (b) Date thereof 6-10-47
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Asenhar Cemetery

18. (a) Signature of funeral director R.O. Wheelock

(b) Address Branon Mo

19. (a) 6-25-47 (b) S.E. Cogswell
(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 2

23. Signature R. Parrish (City or town) MO
Address Reeds Spring Mo Date signed 6-7-47

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

RECEIVED

District Health Officer No. 67

District File Number 747-792

Date Filed JUN 23 1947

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 Minnie J. Welch

Licensed Embalmer No. 2277

P. O. Address Burrton Mo

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.

Registration District No. 352

Primary Registration District No. 619

1. PLACE OF DEATH:

(a) County Taney
(b) City or town Rural
(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

Jacob Rantz

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 _____

6. (b) Name of husband or wife _____

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

7. Birth date of deceased _____ (Month) _____ (Day) _____ (Year)

8. AGE:

Years 89

Months _____

Days _____

If less than one day _____ hr. _____ min.

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

10. Usual occupation _____

11. Industry or business _____

12. Name Janial Rantz

13. Birthplace Wabash Co Ind (City, town, or county) _____ (State or foreign country)

14. Maiden name Christine Perms

15. Birthplace Wabash Co Ind (City, town, or county) _____ (State or foreign country)

16. (a) Informant Jim Rantz

(b) Address Red Springs Mo

17. (a) Burial (Burial, cremation, or removal)

(b) Date thereof _____ (Month) _____ (Day) _____ (Year)

(c) Place: burial or cremation Red Springs Mo

18. (a) Signature of funeral director R. D. Whitelut

(b) Address Branson Mo

19. (a) 6-28-47 (Date received local registrar)

(b) J. E. Cogswell (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Taney

(c) City or town Rural (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 _____, Day _____, Year 1947 (hour) _____ minute _____ M.

21. I hereby certify that I attended the deceased from 10-12-46 to 6-8-47

that I last saw him alive on 6-8-47 and that death occurred on the date and hour stated above.

Immediate cause of death _____

Paralysis of Diaphragm

Due to _____

Due to _____

Other conditions (Include pregnancy within 3 months of death)

Major findings:

Of operations _____

Of autopsy _____

Duration

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 R. C. Parish (M. D. or other) D.O.

Address Red Springs Mo Date signed 6-7-47

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

MOTHER FATHER

SUPPLEMENTARY 8

20527