No. 300
10.48

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THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 28584

BIRTH NO. _____ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. 6914

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

1. PLACE OF DEATH
a. COUNTY .....
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) St. Louis
c. LENGTH OF STAY (In this place) 6-26-68-13 50
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Deaconess Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
a. STATE Missouri b. COUNTY St. Louis
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Webster Groves 4587
d. STREET ADDRESS (If rural, give location) 125 Sylvester Ave.

3. NAME OF DECEASED (Type or Print) a. (First) HARRIETT b. (Middle) HOWE c. (Last) RANKIN

4. DATE OF DEATH (Month) (Day) (Year) AUG-13-1950

5. SEX Female
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed
8. DATE OF BIRTH July 8 1887
9. AGE (In years last birthday) 63 IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At Home
10b. KIND OF BUSINESS OR INDUSTRY .....
11. BIRTHPLACE (State or foreign country) Creston Iowa
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13a. FATHER'S NAME Unknown
13b. MOTHER'S MAIDEN NAME Unknown
14. NAME OF HUSBAND OR WIFE Walter S. Rankin

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. None
17. INFORMANT'S SIGNATURE OR NAME Elizabeth R. Appleton ADDRESS

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, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Carcinoma of the ovary. — INTERVAL BETWEEN ONSET AND DEATH 6 mons +

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) _____
DUE TO (c) _____

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

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) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR? 175X

22. *I hereby certify that I attended the deceased from* Mar 6, 1950, *to* Aug 13, 1950, *that I last saw the deceased alive on* Aug 12, 1950, *and that death occurred at* 2:45 A.M. *from the causes and on the date stated above.*

23a. SIGNATURE Sam F Beam (Degree or title) MDO
23b. ADDRESS 3720 Washington St Louis
23c. DATE SIGNED 8/14/50

24a. BURIAL, CREMATION, REMOVAL (Specify) Removal
24b. DATE Aug. 14 1950
24c. NAME OF CEMETERY OR CREMATORY Graceland Cemetery
24d. LOCATION (City, town, or county) Chicago Illinois (State)

DATE REC'D BY LOCAL REG. AUG 14 1950
REGISTRAR'S SIGNATURE J. B. Gasaten
25. FUNERAL DIRECTOR'S SIGNATURE Parker-Aldrich Funeral Home ADDRESS Webster Groves

(Licensed Embalmer's Statement on Reverse Side)

M.O.

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 Leslie Walch

Licensed Embalmer No. 4395

P. O. Address Jupiter Groves

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.