

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 31341

SEP 29 1952

BIRTH NO. _____ REG. DIST. NO. 128 PRIMARY REG. DIST. NO. 2000 Registrar's No. 867

396

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

1. PLACE OF DEATH a. COUNTY Greene		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY Greene	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Springfield		c. LENGTH OF STAY (In this place) _____	
d. FULL NAME OF HOSPITAL OR INSTITUTION 1123 W. High		d. STREET ADDRESS (If rural, give location) 1123 W. High	

3. NAME OF DECEASED (Type or Print)	a. (First) SARAH	b. (Middle) CATHERINE	c. (Last) RANKIN	4. DATE OF DEATH (Month) (Day) (Year)	Sept. 20 1952
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5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed 2	8. DATE OF BIRTH Nov. 20 1875	9. AGE (In years last birthday) 76	IF UNDER 1 YEAR Month _____ Day _____	IF UNDER 10 HRS. Hour _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY In Home	11. BIRTHPLACE (City and State or Foreign Country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? USA	

13a. FATHER'S NAME George Day	13b. MOTHER'S MAIDEN NAME Susan Krape	14. NAME OF HUSBAND OR WIFE Deceased
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) No	16. SOCIAL SECURITY NO. (If yes, give year or dates of service) No	17. INFORMANT'S SIGNATURE OR NAME Gladys Hart	ADDRESS Springfield, Mo.
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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, asthma, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH 6 days
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Hemorrhage		1894
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Hypertension + Arterio Sclerosis		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Stroke			

19a. DATE OF OPERATION _____	19b. MAJOR FINDINGS OF OPERATION 331X	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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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) _____	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	21f. HOW DID INJURY OCCUR? _____

22. I hereby certify that I attended the deceased from 9-15-1952 to 9-20-1952, that I last saw the deceased alive on _____, 19____, and that death occurred at 9:50A m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) C. E. Feller M.D.	23b. ADDRESS 608 Cherry Springfield	23c. DATE SIGNED 9-20-52
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE Sept. 22, 52	24c. NAME OF CEMETERY OR CREMATORY Bellview Cemetery	24d. LOCATION (City, town, or county) (State) Greene County Mo.
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DATE REC'D BY LOCAL REG. 9-22-52	REGISTRAR'S SIGNATURE Edith Williamson Registrar	25. FUNERAL DIRECTOR'S SIGNATURE J.W. KLINGNER & CO.	ADDRESS SPRINGFIELD, MO.
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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 Max Rhodes

Licensed Embalmer No. 4071

P. O. Address Springfield

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.