

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

60-011638
STATE FILE NUMBER

FILED VS MAR 22 1960

Registration District No. 174 Primary Registration District No. 3035 Registrar's No. 28

1. PLACE OF DEATH a. COUNTY <u>Lafayette</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Lafayette</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Lexington</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>Odessa</u> <u>0540</u>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Lexington Memorial Hospt.</u>		Length of stay <u>1b</u>	d. STREET ADDRESS (If outside, give location) <u>4 block S. Hy. 40.</u>
			Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>Robert</u> Middle <u>J.</u> Last <u>Rankin</u>			4. DATE OF DEATH Month <u>March</u> Day <u>18</u> Year <u>1960</u>		
--	--	--	---	--	--

5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan. 25, 1865</u>	9. AGE (In years last birthday) <u>95</u>	IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>
-----------------------	----------------------------------	---	--	--	--	--

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>employee</u>	11. BIRTHPLACE (City and state or country) <u>Lafayette Co., Mo.</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
---	--	---	--

13a. FATHER'S NAME <u>James A. Rankin</u>	13b. MOTHER'S MAIDEN NAME <u>Martha C. Williams</u>	14. NAME OF HUSBAND OR WIFE <u>Deceased</u>
--	--	--

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>	16. SOCIAL SECURITY NO. <u>none</u>	17. INFORMANT <u>Mrs. Rudy Krause</u>	Address <u>Odessa, Mo.</u>
--	--	--	-------------------------------

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral hemorrhage.</u>		INTERVAL BETWEEN ONSET AND DEATH <u>10 days</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <u>arterial hypertension</u>	<u>?</u>	
DUE TO (c) <u>anemia due to epistaxis</u>	<u>331X</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		19. WAS AUTOPSY PERFORMED? <u>2</u> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>

20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in PART I or PART II of item 18.)
---	---

20c. TIME OF INJURY Hour <u> </u> a.m. <u> </u> p.m. <u> </u>	20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION <u>Lexington</u>	COUNTY <u> </u>	STATE <u> </u>
---	---	--	--	-----------------------	----------------------

21. I attended the deceased from <u>3/17/60</u> to <u>3/18/60</u> and last saw him alive on <u>3/18/60</u> Death occurred at <u>5:00 pm</u> on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <u>Ralph R. Sparks MD</u>	(Degree or title)	22b. ADDRESS <u>Lexington</u>	22c. DATE SIGNED <u>3-19-60</u>
---	-------------------	----------------------------------	------------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>Mar. 20, 1960</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Greenton Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>Near Odessa, Mo.</u>
--	-----------------------------------	--	--

24. FUNERAL DIRECTOR <u>Husman-Sparks,</u>	ADDRESS <u>Odessa, Mo.</u>	25. DATE RECD. BY LOCAL REG. <u>3-19-60</u>	26. REGISTRAR'S SIGNATURE <u> </u>
---	-------------------------------	--	--

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

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
Signature of Student Embalmer

Signed *William F. Sparks*

Licensed Embalmer No. *4431*

P. O. Address *Odessa, M*

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.