

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

=62-017873

STATE FILE NUMBER

Registration District No. 1 Primary Registration District No. 3000 Registrar's No. 156

DO NOT WRITE ON THIS STUB

AMENDED

FILED MAY 21 1962

1. PLACE OF DEATH a. COUNTY Adair		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri COUNTY Lewis	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Kirksville		Length of stay in 1b 14 yrs.	c. CITY OR TOWN Canton Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION Community Nursing Home #1		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 408 Jamison Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last Pearl - Rankins			4. DATE OF DEATH Month Day Year May 13, 1962
5. SEX Male	6. COLOR OR RACE White	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 5-5-1907
9. AGE (last birthday) 55		IF UNDER 1 YEAR Months Days	IF UNDER 24 HR Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None	11. BIRTHPLACE (City and state or country) Albia, Iowa
12. CITIZEN OF WHAT COUNTRY USA		13a. FATHER'S NAME Benjamin F. Rankin	
13b. MOTHER'S MAIDEN NAME Phoebe Coberly		14. NAME OF HUSBAND OR WIFE Never married	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None	17. INFORMANT Address Mrs. Hazel Shaver, Mendon, Ill.
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Circulatory Failure			INTERVAL BETWEEN ONSET AND DEATH minutes
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Acute Congestive Heart Failure			hours
DUE TO (c) Left frontal lobe brain abscess			weeks
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)			PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input 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 Month, Day, Year a.m. p.m.		20d. INJURY OCCURRED WHILE AT WORK <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	COUNTY STATE
21. I attended the deceased from July 17, 1961 to May 13, 1962 and last saw him alive on May 13, 1962 Death occurred at 4:30 P.m. on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE George H. Scherer, D.O. (Degree or title)		22b. ADDRESS Kirksville, Mo.	22c. DATE SIGNED 5-13-62
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE May 16, 1962	23c. NAME OF CEMETERY OR CREMATORY Bluff Springs	23d. LOCATION (City, town, or county) (State) Clark County, Missouri
24. FUNERAL DIRECTOR Carl H. Backley, Canton, Mo. ADDRESS		25. DATE RECD. BY LOCAL REG. May 18, 1962	26. REGISTRAR'S SIGNATURE Doris W. Ratliff

VS 300 Rev. 4/59

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

USE BLACK INK OR TYPEWRITER RIBBON

JUL 31 1962

GEORGE H. SCHEURER, D.D.

Permit Granted May 14, 1962

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 Robert B. Davis
Licensed Embalmer No. 4219

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