

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

**MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH**

Do not use this space.

27152

1. PLACE OF DEATH

County Registration District No. **781**
 Township Primary Registration District No. **1008**
 City (No. **City Hosp # 2**)

File No.
 Registered No. **8370**
 St. Ward)

2. FULL NAME *William Randall*

(a) Residence, No. **4218 W. N. Market St. 11** Ward.

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX <i>male</i>	4. COLOR OR RACE <i>Cal</i>	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED <i>single</i>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF		
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) <i>march 2nd 1903</i>		
7. AGE	YEARS <i>28</i>	MONTHS <i>4</i>
	DAYS <i>29</i>	IF LESS than 1 day, hrs. or min.
OCCUPATION	8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. <i>Labor</i>	
	9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.	
	10. Date deceased last worked at this occupation (month and year)	11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *St. Louis Mo*

13. NAME *Miles Randall*

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Bolton miss*

15. MAIDEN NAME *Mary Berry*

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Bolton miss*

17. INFORMANT *Miles Randall*
(ADDRESS) *4218 W. N. Market*

18. BURIAL, CREMATION, OR REMOVAL PLACE *Greenwood* DATE *8-3-31*

19. UNDERTAKER *A. F. Walton*
(ADDRESS) *2701 St. Charles*

20. FILED *AUG - 3 1931* Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) *July 31 1931*

22. I HEREBY CERTIFY That I attended deceased from *Physician* *Attended* from 19....., to 19.....

I last saw h..... alive on 19..... Death is said to have occurred on the date stated above, at m.

The principal cause of death and related causes of importance were as follows:

Gen Thorwald Date of onset

173 Neck

Other contributory causes of importance:

Homicide

Name of operation Date of
 What test confirmed diagnosis? Was there an autopsy?

23. If death was due to external causes (violence), fill in also the following:
 Accident, suicide, or homicide? Date of injury 19.....
 Where did injury occur? (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place.

Manner of injury
 Nature of injury

24. Was disease or injury in any way related to occupation of deceased?
 If so, specify

(Signed) *S. W. Ferner* M. D.
 (Address) *8/3/31 Dep. Coroner*

