

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 35732
9005
Registrar's No.

Registration District No. 791

Primary Registration District No. 1003

FILED DEC 11 1940

1. PLACE OF DEATH:
(a) County _____
(b) City or town St. Louis
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Deaconess Hosp
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 4 Days (Specify whether _____)
In this community 35 yrs
years, months or days)

3. (a) PRINT FULL NAME William F Randol
3. (b) If veteran, name war None
3. (c) Social Security No. None

4. Sex Male 5. Color or race White
6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Margaret E
6. (c) Age of husband or wife if alive 70 years
7. Birth date of deceased Nov 29th 1862
(Month) (Day) (Year)

8. AGE: Years 77 Months 11 Days 1
If less than one day _____ hr. _____ min.

9. Birthplace Mo
(City, town, or county) (State or foreign country)

10. Usual occupation Brick Layer

11. Industry or business Unemployed

MOTHER FATHER
12. Name Marcus Randol
13. Birthplace Mo
(City, town, or county) (State or foreign country)
14. Maiden name Sarah McKinley
15. Birthplace Mo
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs Margaret E Randol

(b) Address 6740 Fyler Ave

17. (a) Burial (b) Date thereof 11/1/40
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Calvary Cemt

18. (e) Signature of Hannigan & Sheehan Und Co

(b) Address 4415 Washington

19. (a) NOV 1 1940 (b) _____
(Date received in registrar's office)

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo (b) County _____
(c) City or town St. Louis 3
(If outside city or town limits, write "RURAL")
(d) Street No. 6740 Fyler Ave
(If rural, give location)
(e) If foreign born, how long in U. S. A.? Life years.

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month Oct day 30th
year 1940 hour 3:30 A.M. minute _____ M.
21. I hereby certify that I attended the deceased from 9-16
1940 to 10-28, 1940
that I last saw him alive on 10-28, 1940
and that death occurred on the date and hour stated above.

Immediate cause of death Senility
Duration _____

Due to _____
Due to _____

Other conditions Acidosis, result of
(Include pregnancy within 3 months of death)
Major findings: patient refusing to eat
Of operations _____
Of autopsy _____
PHYSICIAN _____
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____

(b) Date of occurrence _____

(c) Where did injury occur? _____
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work? _____ (Specify type of place) (e) Means of injury _____

23. Signature P B Cappel md D. or other _____

Address 3239 Franklin Date signed 11/1/40

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

Dr. Casper
3239 Hammond
10-12pm 6 - 8 pm

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 _____

_____ Registered Apprentice No. _____
working under my personal supervision.

Signed Harmer W. Fritz

Licensed Embalmer No. 3882

P. O. Address _____

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, above space should be left blank.