

FILLED OCT 24 1941

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

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Do not use this space.

1. PLACE OF DEATH

(a) County Reynolds Registration District No. 927
 (b) Township Jackson Primary Registration District No. 111 Registered No. _____
 (c) City Ellington R.F.D. 2 (d) Street No. _____ St. _____
 (If death occurred in Hospital or Institution, write its name instead of street and number)
 (e) Length of residence in city or town where death occurred 84 yrs. 8 mos. 27 ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME John Franklin Randolph

(a) Residence, No. Reynolds County St. (Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Widowed

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF Sarah Randolph (OR) WIFE OF _____

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) 4-18-1856

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
84 8 27

OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. farmer
 9. Industry or business in which work was done, as saw mill, bank, etc. _____
 10. Date deceased last worked at this occupation (month and year) September 1921 11. Total time (years) spent in this occupation 44

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) State Mo. U. S. A.

FATHER 13. NAME BURTON RANDOLPH
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) U. S. A.

MOTHER 15. MAIDEN NAME ELIZABETH WARREN
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) State of Mo.

17. INFORMANT Ellington Mo. R. F. D. 2 Box 1 (ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL PLACE Gold Cemetery DATE January 17, 1941

19. FUNERAL DIRECTOR (NAME) Frank Parker (ADDRESS) Bunker Mo. Minister

20. FILED _____ 19 _____ Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 1/15 1941

22. I HEREBY CERTIFY, That I attended deceased from 1/10 1941, to 1/15 1941
 I last saw him alive on 1/14 1941. Death is said to have occurred on the date stated above, at 10:00 P.M.
 The principal cause of death and related causes of importance were as follows:

Kyfluenga
 338
 Other contributory causes of importance: _____

Name of operation None Date of _____
 What test confirmed diagnosis? ✓ Was there an autopsy? No

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? No
 If so, specify _____
 (Signed) J. H. Kable, M. D.
 (Address) Ellington Mo.

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.

RECEIVED

District Health Officer No. 5,

District File Number 1041-2003

Date Filed _____

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 _____

Licensed Embalmer No. _____

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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 32370

Registration District No. 747

Primary Registration District No. 5981

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Reynolds
(b) City or town Jackson
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether _____)
In this community _____
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County _____
(c) City or town _____ (If outside city or town limits, write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME

John F. Randolph

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

4. Sex m 5. Color or race w 6. (a) Single, widowed, married, divorced w
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased. 4-18-1856
(Month) (Day) (Year)

8. AGE: Years 84 Months 8 Days 3 (If less than one day _____ min.)

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

10. Usual occupation _____

11. Industry of business _____

12. Name _____

13. Birthplace _____ (City, town, or county) (State or foreign country)

14. Maiden name _____ (State or foreign country)

15. Birthplace _____ (City, town, or county) (State or foreign country)

16. (a) Informant _____

(b) Address _____

17. (a) _____ (b) Date thereof _____ (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) Nov 23, 1941 (b) Miss J. J. Peptide
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month _____ Day _____
year 1941 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ to _____, 19____; that I last saw him _____ alive on _____, 19____; and that death occurred on the date and hour stated above.
Immediate cause of death _____

Duration _____

Due to _____

Due to _____

Other conditions _____ (Include pregnancy within 3 months of death)

Major findings: 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 _____ (M. D. or other) _____

Address _____ Date signed _____

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

SUPPLEMENTARY

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