

FILED JAN 20 1942

Registration District No. 496

Primary Registration District No. 3025

1. PLACE OF DEATH:

(a) County Lincoln
 (b) City or town Brookfield City
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution: McCarney Hospital
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution _____
 In this community 4 years 0 (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Lincoln
 (c) City or town Brookfield
 (If outside city or town limits, write "RURAL")
 (d) Street No. 122 E. Canal
 (If rural, give location)
 (e) If foreign born, how long in U. S. A.? 0 years.

3. (a) PRINT FULL NAME ROBERT SILAS RANDLEMAN

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 Married

6. (b) Name of husband or wife Violet Randleman 6. (c) Age of husband or wife if alive 28 years

7. Birth date of deceased May 24 1912
 (Month) (Day) (Year)

8. AGE: Years 29 Months 7 Days 7 If less than one day _____ hr. _____ min.

9. Birthplace Dallas County Missouri
 (City, town, or county) (State or foreign country)

10. Usual occupation Barber

11. Industry or business _____

MOTHER FATHER
 { 12. Name Allert N. Randleman
 13. Birthplace Dallas County Missouri
 (City, town, or county) (State or foreign country)
 14. Maiden name May Turner
 15. Birthplace Polk County Missouri
 (City, town, or county) (State or foreign country)

16. (a) Informant's own signature Violet Randleman
 (b) Address Brookfield

17. (a) Removal (b) Date thereof Jan 15 1942
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Buffalo Missouri

18. (a) Signature of funeral director W. H. Cannon
 (b) Address Brookfield

19. (a) 1-2-1942 (b) W. H. Cannon
 (Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan day 1
 year 1942 hour 3 minute 0 M.

21. I hereby certify that I attended the deceased from Jan 1, 1941, to Jan 1, 1941; that I last saw him alive on Jan 1, 1941; and that death occurred on the date and hour stated above.

Immediate cause of death _____
Cerebral Aneurysm
 Due to _____
 Due to _____
 Other conditions (Include pregnancy within 3 months of death) _____

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically

Major findings: _____
 Of operations _____
 Of autopsy _____

22. If death was due to external causes, fill in the following:
 (a) Accident, suicide, or homicide (specify) accident
 (b) Date of occurrence Jan 1 1941
 (c) Where did injury occur Brookfield Lincoln mo
 (City or town) (County) (State)
 (d) Did injury occur in or about home, on farm, in industrial place, in public place?
S. Main St.
 While at work? _____ (Specify type of place) (a) Means of injury _____
 23. Signature W. H. Cannon (M. D. or other) W. H. Cannon
 Address Brookfield mo Date signed 1-1-41

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

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

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.....

J. H. Blacklock....., Registered Apprentice No.....
working under my personal supervision.

Signed.....
J. H. Blacklock
Licensed Embalmer No. *2246*
P. O. Address *Brookfield 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 this body is not embalmed, above space should be left blank.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 42394

Registration District No. 496

Primary Registration District No. 3025

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Linn
(b) City or town Brookfield
(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 Robert S. Randleman

3. (b) If veteran, name war _____ 3. (c) Social Security No. 491-05-1220

4. Sex m 5. Color or race w 6. (a) Single, widowed, married, divorced m

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased May 24 1912
(Month) (Day) (Year)

8. AGE: Years 29 Months 7 Days _____
(If less than one day _____ min.)

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

10. Usual occupation _____

11. Industry of business _____

MOTHER FATHER

12. Name _____

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

14. Maiden name _____

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) _____ (b) _____
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan Day _____
year 1942 hour _____ minute _____ M.

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

Cerebral Concussion
Due to Probable Fracture of skull.

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

Major findings: Of operations 170 cc blood
Of autopsy 22

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) accident

(b) Date of occurrence Jan 19 1942 058

(c) Where did injury occur? Brookfield Linn mo
(City, town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?
Corner main + Broad St
While at work? no (Specify type of place)
(e) Type of place of injury auto

23. Signature Dr. H. H. Patton (M. D. or other) cc
Address Brookfield mo Date signed 1-19-42

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

SUPPLEMENTARY

