S. No. 2
M—5-42
v. 5-17-39
X32873

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 17106

FILED JUN 7 1943

Registration District No. 999

Primary Registration District No. 1002

Registrar's No. 2067

1. PLACE OF DEATH:

(a) County Jacjson

(b) City or town Kansas City Mo.
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: Conley Hosp. D
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 1 Day (Specify whether
In this community 6 Mo
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Jackson 48

(c) City or town 905 Locust Kansaw City 3
(If outside city or town limits, write "RURAL")

(d) Street No. 905 Locust 8
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country

3. (a) PRINT FULL NAME James Proctor Randol

3. (b) If veteran, name war No

3. (c) Social Security No. 407-10-1046

4. Sex Male 0

5. Color or race Wh

6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Frances Randol

6. (c) Age of husband or wife if alive 56 years

7. Birth date of deceased Mar. 26 1884
(Month) (Day) (Year)

8. AGE: 59 Years | Months 1 | Days 4 | If less than one day ___ hr. ___ min.

9. Birthplace Mo (City, town, or county) 0 (State or foreign country)

10. Usual occupation Labor C&A R.R.

11. Industry or business

FATHER
12. Name James S Randol 0
13. Birthplace Mo (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Ellen Proctor
15. Birthplace Mo (City, town, or county) 0 (State or foreign country)

16. (a) Informant James R. Randol
(b) Address Clearwater Flor.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof May 4 43 (Month) (Day) (Year)
(c) Place: burial or cremation Slater Mo

18. (a) Signature of funeral director Wornall Fun Home
(b) Address 7406 Wornall Rd

19. (a) 3/3/43 (Date received local registrar) (b) M. M. Crowe (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 30
year 1943 hour 3:00 minute P. M.

21. I hereby certify that I attended the deceased from April 29, 1943 to April 30, 1943
that I last saw him alive on April 30, 1943
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Asphyxia	
Due to Pneumonic Congestion	
Due to Meningococcic Meningitis	2 or 3 wks.
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations None
Of autopsy None

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

23. Signature C. L. Anderson (M. D. or other) DO
Address 619 Garfield Kansas City Mo. Date signed 4-30-43

361

(Licensed Embalmer's Statement on Reverse Side)

NOV 29 1949

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 Harlyn Roe, Registered Apprentice No. ....., working under my personal supervision.

Signed Harlyn Roe

Licensed Embalmer No. 2810

P. O. Address K.C. 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, fact should be so stated above.