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DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **31549**

FILED SEP 30 1943

Registration District No. **103**

Primary Registration District No. **5345**

Registrar's No. **48**

1. PLACE OF DEATH:

(a) County **Dent**  
(b) City or town **Rural Dent**  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
**Station Hospital, Rt. Leonard Wood, Mo.**  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution **DOA**  
(Specify whether years, months or days) **3**

3. (a) PRINT FULL NAME **Homer Malcolm Randle 2nd Lt.**

3. (b) If veteran, name war **-----** 3. (c) Social Security No. **-----**

4. Sex **Male** 5. Color or race **White** 6. (a) Single, widowed, married, divorced **Unknown**

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

7. Birth date of deceased **May 25 1921**  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
**22 3 10** **-----** hr. **-----** min.

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

10. Usual occupation **U.S. AAC** **0-680296**

11. Industry or business **Reeves Prov. Gp. - 346 Bomb Gp.**

MOTHER FATHER

12. Name **Joe E. Randle**

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

14. Maiden name **Unknown**

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

16. (a) Informant **U.S. Army Records**

(b) Address **Army Air Base, Dyersburg, Tenn.**

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

(c) Place: burial or cremation **City of Dent**

18. (a) Signature of funeral director **W. E. Helms**

(b) Address **Lebanon Mo**

19. (a) **Sept 8, 1943** (b) **Robert A. Murray, M.D.**  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Vermont** (b) County **999**  
(c) City or town **Westburke** **43**  
(If outside city or town limits, write "RURAL")  
(d) Street No. **Unknown**  
(If rural, give location)  
(e) Citizen of foreign country? **No** (Yes or No)  
If yes, name country **2**

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Sept** day **4**  
year **1943** hour **about 4** minute **00** P. M.

21. I hereby certify that I attended the deceased from **-----**  
**-----** 19. 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 **Multiple contusions, lacerations and fractures**

Due to **Airplane Crash**

Due to **-----**

Other conditions **None**  
(Include pregnancy within 3 months of death)

Major findings: Of operations **None**

Of autopsy **None**

Duration

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 033**

(b) Date of occurrence **Sept. 4, 1943**

(c) Where did injury occur? **Rural Dent Mo.**  
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?  
**Rural--airplane crash**  
While at work? **Yes** (Specify type of place) **airplane & ground**  
(e) Means of injury

23. Signature **Robert A. Murray, M.D.** (M. D. or other) **40**  
Address **Ft. Leonard Wood, Mo.** Date signed **Sept 8, 1943**

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

**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.....

..... *Myself* ....., Registered Apprentice No. ....  
working under my personal supervision.

Signed: *W. E. Helman* .....

Licensed Embalmer No. *4107* .....

P. O. Address: *Lebanon* .....

**Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)**

**If this body is not embalmed, fact should be so stated above.**

RECORD  
STATE OF MISSOURI  
DEPARTMENT OF HEALTH  
DIVISION OF PUBLIC HEALTH  
BUREAU OF HEALTH OFFICERS  
ST. LOUIS, MISSOURI

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. \_\_\_\_\_

Registration District No. 100

Primary Registration District No. 5385

Registrar's No. 48

1. PLACE OF DEATH:

(a) County Grant  
 (b) City or town Rural-Meramec Imp  
(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 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

Homer Malcolm Randle 2nd

MEDICAL CERTIFICATION

3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

20. DATE OF DEATH: Month Sept  
 year 1943 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

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

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

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

7. Birth date of deceased May 25 1911  
(Month) (Day) (Year)

8. AGE: Years 22 Months 3 Days \_\_\_\_\_ If less than one day \_\_\_\_\_ min.

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

10. Usual occupation \_\_\_\_\_

11. Industry or business \_\_\_\_\_

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)

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

Major findings:  
 Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

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 \_\_\_\_\_

PLEASE PRINT—USE ULTRA-VIOLET INK TO MAKE A PERMANENT RECORD

SUPPLEMENTARY

MOTHER, FATHER

PHYSICIAN  
 \_\_\_\_\_  
 Underline the cause to which death should be charged statistically.

Duration

31549

MAY 17 1944