

FILED DEC 17 1943

Registration District No. 336

Primary Registration District No. 6125

Registrar's No. \_\_\_\_\_

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

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**1. PLACE OF DEATH:**

(a) County Shannon

(b) City or town Rural Cato (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 45 (Specify whether \_\_\_\_\_)

In this community \_\_\_\_\_ years, months or days

3. (a) PRINT FULL NAME Leander Randall

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 Polly Randall 6. (c) Age of husband or wife if alive 63 years

7. Birth date of deceased Aug 22 1865 (Month) (Day) (Year)

8. AGE: Years 78 Months 4 Days 13 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

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

10. Usual occupation Farmer

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

MOTHER FATHER

12. Name George Randall

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

14. Maiden name Elizabeth Madison

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

16. (a) Informant Miss Polly Randall

(b) Address Summersville Mo

17. (a) \_\_\_\_\_ (b) Date thereof 12 5-43 (Month) (Day) (Year)

(c) Place: burial or cremation Summersville Cemetery

18. (a) Signature of funeral director Engel Vellert

(b) Address Cuba Mo

19. (a) 12-8-43 (Date received local registrar) (b) Frank Hyde MD (Registrar's signature)

**2. USUAL RESIDENCE OF DECEASED:**

(a) County Shannon State Mo

(b) City or town Rural Cato Ind (If outside city or town limit write "RURAL")

(c) Street No. \_\_\_\_\_ (If rural, give location)

(d) If foreign born, how long in U. S. A? 0 years.

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Month Dec day 4 year 1943 hour 2 minute 50 pm

21. I hereby certify that I attended the deceased from Dec 4 9: PM 1943 to 10 AM Dec 4 1943 that I last saw him alive on Dec 4 10 AM 1943 and that death occurred on the date and hour stated above.

Immediate cause of death Disease of Coronary Arteries Duration \_\_\_\_\_

Due to Cerebral Hemorrhage

Due to apoplexy

Other conditions (Include pregnancy within 3 months of death) g3a

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 Dr. Frank Hyde MD (M. D. or other) Dec 6 Address Summersville Mo Date signed Dec 6

RECEIVED

District Health Officer No. 5,

District File Number 1243918

Date Filed 12-15-43

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**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 Frank E. Wood

Licensed Embalmer No. 4026

P. O. Address Houston, 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.**