

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

40320

State File No.

FILED DEC 22 1944
Registration District No. 149

Primary Registration District No. 1002

Registrar's No. 5035

1. PLACE OF DEATH:

(a) County Jackson

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

(c) Name of hospital or institution:
General Hospital No. 2
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 10-13-44-11-9-44
(Specify whether years, months or days) 38 years

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson

(c) City or town Kansas City Sittle Blue
(If outside city or town limits, write "RURAL")

(d) Street No. Old Folks Home
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME SAM RANDOLPH

3. (b) If veteran, name war no

3. (c) Social Security No. none

4. Sex Male 5. Color or race Negro

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

6. (b) Name of husband or wife unknown

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

7. Birth date of deceased unknown
(Month) (Day) (Year)

8. AGE: Years about 72 Months _____ Days _____ If less than one day _____ hr. _____ min.

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

10. Usual occupation Unemployed

11. Industry or business _____

MOTHER FATHER { 12. Name unknown

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

14. Maiden name unknown

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

16. (a) Informant Record Clerk

(b) Address General Hospital No. 2

17. (a) Burial (b) Date hereof 12-13-44
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director Wm. J. Holmquist

(b) Address City Mortician

19. (a) 12-12-44 (b) T. E. Brown
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov. day 9
year 1944 hour 8:15 minute _____ A. M.

21. I hereby certify that I attended the deceased from Oct. 13
19 44 to Nov. 9 19 44

that I last saw him alive on Nov. 9 19 44
and that death occurred on the date and hour stated above.

Immediate cause of death Gangrene of left foot Duration _____

Due to Arterio Sclerotic Toxemia

Due to _____

Other conditions 98:2
(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 W. E. Brown (M. D. or other) _____

Address Gen. Hosp. #2 600 E. 22nd Date signed 11-9-44

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

48
8

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, fact should be so stated above.