

THE DIVISION OF HEALTH OF THE STATE OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **6951**
Registrar's No. **54**

FILED MAR 10 1952

BIRTH NO. _____ REG. DIST. NO. **384** PRIMARY REG. DIST. NO. **6093**

976
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH a. COUNTY Saline		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Clay	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Rural, Marshall Twp.		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Liberty	
c. LENGTH OF STAY (in this place) 13-6-20		d. STREET ADDRESS (If rural, give location) R.R.	
d. FULL NAME OF HOSPITAL OR INSTITUTION Missouri State School			

3. NAME OF DECEASED (Type or Print) a. (First) Cecil b. (Middle) Ray c. (Last) Randolph			4. DATE OF DEATH (Month) (Day) (Year) 3-4-52		
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5. SEX male	6. COLOR OR RACE white	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) never married	8. DATE OF BIRTH 4-28-1928	9. AGE (In years last birthday) 23	IF UNDER 1 YEAR Months 10 Days 6	IF UNDER 24 HRS. Hours 6 Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none	10b. KIND OF BUSINESS OR INDUSTRY none	11. BIRTHPLACE (State or foreign country) Missouri	12. CITIZEN OF WHAT COUNTRY? U.S.A.
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13a. FATHER'S NAME John Randolph	13b. MOTHER'S MAIDEN NAME Ellen Blackburn	14. NAME OF HUSBAND OR WIFE never married
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no	16. SOCIAL SECURITY NO. none	17. INFORMANT'S SIGNATURE OR NAME Record, Mo. State School, Marshall, Mo. ADDRESS
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Myocardial Degeneration		INTERVAL BETWEEN ONSET AND DEATH 1 months
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Spastic Paralysis		
	DUE TO (c) Epilepsy		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION 351 X	20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
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21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (m.)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
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22. I hereby certify that I attended the deceased from 10, 1950, to March 4, 1952, that I last saw the deceased alive on 3-3-, 1952, and that death occurred at 6:50 a.m., from the causes and on the date stated above.

23a. SIGNATURE C. E. Salyer (Degree or title) M.D.	23b. ADDRESS Marshall, Mo.	23c. DATE SIGNED 3-4-52
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24a. BURIAL, CREMATION, REMOVAL (Specify) Removal 4	24b. DATE Mch. 8, 1952	24c. NAME OF CEMETERY OR CREMATORY. Kirksville School Ostedopathy, Kirksville, Mo.	24d. LOCATION (City, town, or county) (State)
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DATE REC'D BY LOCAL REG. Mar. 7-1952	REGISTRAR'S SIGNATURE Bidney T. Gray	25. FUNERAL DIRECTOR'S SIGNATURE Campbell-Lewis ADDRESS Marshall, Mo.
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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~~ _____

_____, Student Embalmer No. _____

working under my personal supervision.

Signed _____
Student Embalmer

Signed

James A. Lewis Jr.

Licensed Embalmer No. *4709*
P. O. Address *Marshall, 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.