

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

33734

State File No.

BIRTH NO. _____ REG. DIST. NO. 141 PRIMARY REG. DIST. NO. 3025 Registrar's No. 39

1. PLACE OF DEATH a. COUNTY <u>Howell</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>uzark</u>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>West Plains</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Bakersfield</u>	
c. LENGTH OF STAY (In this place) <u>1 day</u>		d. STREET ADDRESS (If rural, give location) <u>0770 /</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Stoll's Hospital</u>			

3. NAME OF DECEASED (Type or Print)	a. (First) <u>HOMER</u>	b. (Middle) <u>EARL</u>	c. (Last) <u>RAND</u>	4. DATE OF DEATH (Month) (Day) (Year) <u>October 6, 1954</u>
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5. SEX <u>Male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>MARRIED</u>	8. DATE OF BIRTH <u>Oct. 4, 1899</u>	9. AGE (In years last birthday) <u>55</u>	IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u>	IF UNDER 24 HRS Hours <u>0</u> Mins. <u>0</u>
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>farming</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>farm</u>	11. BIRTHPLACE (State or foreign country) <u>Melbourne, Arkansas</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
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13a. FATHER'S NAME <u>William S. Rand</u>	13b. MOTHER'S MAIDEN NAME <u>Alton Cooper</u>	14. NAME OF HUSBAND OR WIFE <u>Ida Mae Rand</u>
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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) <u>No</u>	16. SOCIAL SECURITY NO. <u>431-34-4335</u>	17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Mrs. Ida Mae Rand Bakersfield, Mo</u>
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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, asthma, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH <u>30 hrs</u>
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Massive gangrene small intestine</u>		
	ANTECEDENT CAUSES <u>Mesenteric thrombosis</u> Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			

19a. DATE OF OPERATION <u>10 6 54</u>	19b. MAJOR FINDINGS OF OPERATION <u>Massive gangrene small intestine</u>	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" 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 5 54, 1954, to 10 6 54, 1954, that I last saw the deceased alive on 10 6 54, and that death occurred at 8:50 P.M., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <u>J. B. Stoll M.D.</u>	23b. ADDRESS <u>West Plains Mo</u>	23c. DATE SIGNED <u>10 9 54</u>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	24b. DATE <u>10/9/54</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Bakersfield Cemetery</u>	24d. LOCATION (City, town, or county) (State) <u>Bakersfield Missouri</u>
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DATE REC'D BY LOCAL REG. <u>10-12-54</u>	REGISTRAR'S SIGNATURE <u>Beatrice Cook</u>	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Carter Funeral service salem, Ark.</u>
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WRITE PLAINLY—USING 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 _____

Student Embalmer No. _____

working under my personal supervision.

Student
Student Embalmer

Signed *Leland Carter*

Licensed Embalmer No. *4516*

P. O. Address *Thayer, Md.*

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.