

REGISTRATION DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

60-000165

LED VS JAN 20 1960

Registration District No. 032 Primary Registration District No. _____ Registrar's No. 7

STATE FILE NUMBER

DED

1. PLACE OF DEATH a. COUNTY <u>Bollinger</u> b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Lutesville</u> Length of stay in lb <u>1 month</u> c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Bond Nursing Home</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Bollinger</u> c. CITY OR TOWN <u>Belma</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> d. STREET ADDRESS (If outside, give location) _____ Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print) First <u>RANZY</u> Middle <u>W.</u> Last <u>RANDOLPH</u>				4. DATE OF DEATH Month <u>January</u> Day <u>11</u> Year <u>1960</u>											
5. SEX <u>male</u>		6. COLOR OR RACE <u>White</u>		7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <u>10-26-1873</u>		9. AGE (last birthday) <u>86</u>		IF UNDER 1 YEAR Months <u>2</u> Days <u>15</u>		IF UNDER 24 HR Hours _____ Min. _____			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Ret. Farmer</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Farming</u>				11. BIRTHPLACE (City and state or country) <u>Zalma, Mo.</u>				12. CITIZEN OF WHAT COUNTRY <u>U.S.</u>			
13a. FATHER'S NAME <u>William Randolph</u>				13b. MOTHER'S MAIDEN NAME <u>not none</u>				14. NAME OF HUSBAND OR WIFE <u>Marie Gray Randolph</u>							
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>none</u>				17. INFORMANT <u>Alva Randolph, Zalma, Mo.</u>				Address _____			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:												INTERVAL BETWEEN ONSET AND DEATH			
IMMEDIATE CAUSE (a) <u>Pneumonia</u>															
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>influenza</u> DUE TO (c) _____															
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Cardiac Decompensation</u>										PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown					
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT <input type="checkbox"/>		SUICIDE <input type="checkbox"/>		HOMICIDE <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)							
20c. TIME OF INJURY Hour _____ a.m. _____ p.m. Month, Day, Year _____				20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION		COUNTY		STATE			
21. I attended the deceased from <u>10/10/58</u> to <u>1/11/60</u> and last saw him alive on <u>1/11/60</u> Death occurred at _____ p.m. on the date stated above, and to the best of my knowledge, from the causes stated.															
22a. SIGNATURE (Degree or title) <u>John J. Myers, D.D.</u>						22b. ADDRESS <u>Lutesville Mo</u>				22c. DATE SIGNED <u>1/15/60</u>					
23a. BURIAL CRYPTON, or REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>1-14-60</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Berony</u>				23d. LOCATION (City, town, or county) <u>Bollinger Co., Mo</u>							
24. GENERAL DIRECTOR <u>W. H. May</u> ADDRESS <u>Advance, Mo</u>				25. DATE RECD. BY LOCAL REG. <u>1-18-60</u>				26. REGISTRAR'S SIGNATURE <u>Mrs. Buford Crider</u>							

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by _____
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Wm H. Mowry

Licensed Embalmer No. 4640

P. O. Address Advocate

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.