V. S. No. 2.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

PLACE OF DEATH

County Cape Girardeau

Township do

or

Village

or

City Cape Girardeau (NO. ..... St.; ..... Ward)

Registration District No. 125

Primary Registration District No. 3009

File No. 14059

Registered No. 1574

[If death occurred in a hospital or institution, give its NAME instead of street and number]

FULL NAME Butler Randell

PERSONAL AND STATISTICAL PARTICULARS

SEX: Male

COLOR OR RACE: Colored

SINGLE MARRIED WIDOWED OR DIVORCED (Write the word): Single

DATE OF BIRTH: Dec (Month) 14 (Day), 1 (Year)

AGE: 50 yrs. 4 mos. 1 ds.

If LESS than 1 day, ... hrs. or ..... min.?

OCCUPATION
(a) Trade, profession, or particular kind of work: Cook
(b) General nature of industry, business, or establishment in which employed (or employer):

BIRTHPLACE (City or town, State or foreign country): Cape Girardeau

PARENTS

NAME OF FATHER: Alexander Randol

BIRTHPLACE OF FATHER (City or town, State or foreign country): Cape Girardeau

MAIDEN NAME OF MOTHER: Louise Minton

BIRTHPLACE OF MOTHER (City or town, State or foreign country): Cape Girardeau

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Leona Williams

(ADDRESS) Cape Girardeau Mo

Filed April 17 1917 R. W. Tissell REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH: April (Month) 15 (Day), 1917 (Year)

I HEREBY CERTIFY, that I attended deceased from Mar 21, 1917, to April 14, 1917, that I last saw him alive on April 14, 1917, and that death occurred, on the date stated above, at 8 A m.

The CAUSE OF DEATH was as follows:

Paretic Dementia

83

67

(Duration) ..... yrs. ..... mos. 20 ds.

Contributory (SECONDARY) Heart failure

(Duration) ..... yrs. ..... mos. 3 ds.

(Signed) John W. Patterson M. D.

April 17 1917 (Address) 106 Broadway

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted if not at place of death?

Former or usual residence

PLACE OF BURIAL OR REMOVAL: Old Catholic Cem

DATE OF BURIAL: Apr 17 1917

UNDERTAKER: Walther F. & U. Co

ADDRESS: Cape Girardeau

PLACE OF DEATH

County .....

Township .....
or
Village .....
or
City ..... (NO. ..... St. ..... Ward)

MISSOURI STATE BOARD OF HE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

Registration District No. ..... File No. .....

Primary Registration District No. ..... Registered No. .....

[If death o hospital or give its NA of street and

FULL NAME .....

PERSONAL AND STATISTICAL PARTICULARS

SEX	COLOR OR RACE	SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word)

DATE OF BIRTH ..... (Month) ..... (Day) ....., (Year)

AGE ..... yrs. ..... mos. ..... ds.

If LESS than 1 day, ... hrs. or ..... min.?

OCCUPATION
(a) Trade, profession, or particular kind of work .....

(b) General nature of industry, business, or establishment in which employed (or employer) .....

BIRTHPLACE (City or town, State or foreign country) .....

PARENTS

NAME OF FATHER .....

BIRTHPLACE OF FATHER (City or town, State or foreign country) .....

MAIDEN NAME OF MOTHER .....

BIRTHPLACE OF MOTHER (City or town, State or foreign country) .....

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) .....

(ADDRESS) .....

Filed ....., 191..., ...
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH ..... (Month) ..... (Day)

I HEREBY CERTIFY, that I attended decease ....., 191..., to .....,
that I last saw h ..... alive on .....,
and that death occurred, on the date stated above, at .....
The CAUSE OF DEATH* was as follows:

.....

.....

..... (Duration) ..... yrs. ..... mos.

Contributory (SECONDARY) ..... (Duration) ..... yrs. ..... mos.

(Signed) .....

....., 191... (Address) .....

*State the Disease Causing Death, or, in deaths from Violent Ca (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANS RECENT RESIDENTS)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

PLACE OF BURIAL OR REMOVAL	DATE OF BURIA
UNDERTAKER	ADDRESS

Revised United States Standard

"Typhoid pneumonia"); *Lobar pneumonia; Broncho-pneumonia* ("Pneumonia," unqualified, is indefinite);