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 Cooper Co

Township La Mine

or

Village —

or

City — (NO. ____ St.: ____ Ward)

Registration District No. 217

Primary Registration District No. 5308

File No. 21942

Registered No. ____

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

FULL NAME Dorsey Hellie Randolph.

PERSONAL AND STATISTICAL PARTICULARS

SEX: Girl

COLOR OR RACE: White

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

DATE OF BIRTH: Dec (Month) 2nd (Day), 1917 (Year)

AGE: 2 yrs. 7 mos. 8 ds.

If LESS than 1 day, — hrs. or — min.?

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

BIRTHPLACE (City or town, State or foreign country): Cooper Co Mo

PARENTS

NAME OF FATHER: Preston J. Randolph

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

MAIDEN NAME OF MOTHER: Eva May Root

BIRTHPLACE OF MOTHER (City or town, State or foreign country): Cooper Co. Mo

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) H. B. Gibson

(ADDRESS) Blackwater Mo

Filed July 15 1919. M. P. Hoffman REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH: July ~~July~~ June (Month) 10th (Day), 1919 (Year)

I HEREBY CERTIFY, that I attended deceased from ~~July 2nd~~ June 25, 1919, to July 10, 1919, that I last saw her alive on July 10th, 1919, and that death occurred, on the date stated above, at 1:30 a.m.

The CAUSE OF DEATH* was as follows:

Ileo-colitis acute

105

(Duration) — yrs. — mos. 15 ds.

Contributory (SECONDARY) ____

(Duration) ____ yrs. ____ mos. ____ ds.

(Signed) J. R. Durrett M. D.

July 10, 1915 (Address) Blackwater Mo

*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: Pinnacle Cemetery

DATE OF BURIAL: July 11, 1919

UNDERTAKER: Irvin & Day

ADDRESS: Blackwater Mo

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

PLACE OF DEATH

County _____

Township _____ Registration District No. _____ File No. _____

or

Village _____ Primary Registration District No. _____ Registered No. _____

or

City _____ (NO. _____ _____ St.; _____ Ward)

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

FULL NAME _____

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.

PERSONAL AND STATISTICAL PARTICULARS

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

DATE OF BIRTH _____ (Month) _____ (Day), 1_____ (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), 191____ (Year)

I HEREBY CERTIFY, that I attended deceased from _____, 191____, to _____, 191____, that I last saw h_____ alive on _____, 191____; and that death occurred, on the date stated above, at _____ m.

The CAUSE OF DEATH* was as follows:

_____

_____

_____

_____ (Duration) _____ yrs. _____ mos. _____ ds.

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

(Signed) _____ M. D.

_____, 191____ (Address) _____

*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	DATE OF BURIAL _____, 191____
UNDERTAKER	ADDRESS