

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

Do not use this space.

19539

1. PLACE OF DEATH

County Jackson
Township Plan
City K.C. Mo. (No. 4206 Walnut St)

Registration District No. 399
Primary Registration District No. 1022

File No. _____
Registered No. [2539] St. _____ Ward _____

2. FULL NAME

Harvey L. Rand
(a) Residence No. 4206 Walnut St. Ward 7
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds. (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)

Married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

Sarah Lee Rand

6. DATE OF BIRTH (MONTH, DAY AND YEAR)

Apr - 4 - 1859

7. AGE

YEARS	MONTHS	DAYS	If LESS than 1 day,hrs. ormin.
71	2	13	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. Lumberman
(b) General nature of industry, business, or establishment in which employed (or employer).....
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN)

(STATE OR COUNTRY) Ohio

10. NAME OF FATHER

William Rand

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY) Ohio

12. MAIDEN NAME OF MOTHER

Orinda Chapman

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY) Ohio

14.

INFORMANT Mrs Sarah Lee Rand
(Address) 4206 Walnut Ave K.C. Mo.

15.

FILED 6/18, 1930 M. M. Cerome
REGISTRAR

3

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) June 17 1930

17. I HEREBY CERTIFY, That I attended deceased from Feb 26 1926 to Jun 17 1930
that I last saw him alive on June 17 1930, and that death occurred, on the date stated above, at 7:30 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

cerebral apoplexy
arteriosclerosis - hyertension
(duration) yrs. 4 mos. 0 ds.
CONTRIBUTORY (SECONDARY)

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH

DID AN OPERATION PRECEDE DEATH? DATE OF

WAS THERE AN AUTOPSY?

WHAT TEST CONFIRMED DIAGNOSIS?

(Signed) W. C. Gullett, M.D.
6/18, 1930 (Address) Brookside Bldg

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) Whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL

DATE OF BURIAL

M. M. Oriah June 20 1930

20. UNDERTAKER

ADDRESS

Mrs. C. L. Foster K.C. Mo.

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.

1225 Rialto Yi-3647
5650 High Drive Hi-5500