

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

Do not use this space.

**23867**

**1. PLACE OF DEATH**

County Pike  
Township Quinn  
City (No. \_\_\_\_\_) \_\_\_\_\_

Registration District No. 684  
Primary Registration District No. 5912

File No. \_\_\_\_\_  
Registered No. 19  
St. \_\_\_\_\_ Ward \_\_\_\_\_

**2. FULL NAME**

Alex Randall

(a) Residence, No. \_\_\_\_\_ St. \_\_\_\_\_ Ward \_\_\_\_\_  
(Usual place of abode) (If nonresident, give city or town and State)  
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.

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX male 4. COLOR OR RACE colored 5. SINGLE, MARRIED, WIDOWED OR DIVORCED married  
*(write the word)*

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Oct 6 - 1859

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.  
70 9 5

**8. OCCUPATION OF DECEASED**

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

**9. BIRTHPLACE (CITY OR TOWN)**

Virginia  
(STATE OR COUNTRY) Pike Co.

**10. NAME OF FATHER**

X Randall

**11. BIRTHPLACE OF FATHER (CITY OR TOWN)**

Virginia  
(STATE OR COUNTRY)

**12. MAIDEN NAME OF MOTHER**

Annie X X

**13. BIRTHPLACE OF MOTHER (CITY OR TOWN)**

Virginia  
(STATE OR COUNTRY)

**14.**

INFORMANT Sallie I Rudd  
(Address) Ft Madison Ia

**15.**

REGISTRAR W. J. Summers  
Address 8110 30 3419 Ave @

**2 MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) July 11<sup>th</sup> 1920

17. I HEREBY CERTIFY, That I attended deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_, that I last saw h\_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_, and that death occurred, on the date stated above, at \_\_\_\_\_ m.

**THE CAUSE OF DEATH\* WAS AS FOLLOWS:**

Heart Failure caused by Heart Distention  
191 (duration) yrs. mos. ds.

**CONTRIBUTORY (SECONDARY)**

194 (duration) yrs. mos. ds.

**18. WHERE WAS DISEASE CONTACTED**

IF NOT AT PLACE OF DEATH \_\_\_\_\_

8 DID AN OPERATION PRECEDE DEATH? DATE OF \_\_\_\_\_

WAS THERE AN AUTOPSY? \_\_\_\_\_

**WHAT TEST CONFIRMED DIAGNOSIS?**

(Signed) J. S. Hendry M. D.

7-11-1920 (Address) Bowling Green Mo

\*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**

Knob Cemetery

7-14 1920

**20. UNDERTAKER**

**ADDRESS**

Grace Bowfheld

Bowling Green Mo

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.

AUG 26 1920

PARENTS

