

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

Do not use this space.

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File No. \_\_\_\_\_  
Registered No. **1927**  
St. \_\_\_\_\_ Ward \_\_\_\_\_

**1. PLACE OF DEATH**

County **Jackson** Registration District No. \_\_\_\_\_  
Township **Kaw** Primary Registration District No. \_\_\_\_\_  
City **Kansas City** (No. **518 Bellefontaine**)

**2. FULL NAME** **Bettie C. Randall**

(a) Residence, No. **518 Bellefontaine** St. \_\_\_\_\_ Ward \_\_\_\_\_  
(Usual place of abode) (If nonresident, give city or town and State)

Length of residence in city or town where death occurred **35** yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX **Female** 4. COLOR OR RACE **White** 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) **Widowed**

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) **Feb. 24, 1854**

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.  
**79**                      **2**                      **10 1/2**

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. **At Home**

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.

10. Date deceased last worked at this occupation (month and year) 11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) **Lexington, Mo.**

13. NAME **Josrph Christopher**

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) **Ky**

15. MAIDEN NAME **Amerina Robinson**

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) **Ky**

17. INFORMANT **Robert B. Randall**  
(ADDRESS) **5837 Oak**

18. BURIAL, CREMATION, OR REMOVAL PLACE **Woodlawn Cem, Ind.**

19. UNDERTAKER **Wagner Funeral Home**  
(ADDRESS) **204 W. Linwood**

20. FILED **May 8 1933 7:30 P.M. Corone**  
**Registrar.**

**MEDICAL CERTIFICATE OF DEATH**

21. DATE OF DEATH (MONTH, DAY, AND YEAR) **May 6, 33** 19

22. I HEREBY CERTIFY, That I attended deceased from **Mar 33**, 19**33**, to **May 6**, 19**33**

I last saw h. or alive on **May 6**, 19**33**. Death is said to have occurred on the date stated above, at **11:57** p.m.

The principal cause of death and related causes of importance were as follows:

**Lobar Pneumonia (Right Lung)** Date of onset **May 4**

**Hepatitis**  
**Chronic Nephritis**

Name of operation \_\_\_\_\_ Date of \_\_\_\_\_  
What test confirmed diagnosis? \_\_\_\_\_ Was there an autopsy? \_\_\_\_\_

23. If death was due to external causes (violence), fill in also the following:  
Accident, suicide, or homicide? \_\_\_\_\_ Date of injury \_\_\_\_\_, 19 \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (Specify city or town, county, and State)  
Specify whether injury occurred in industry, in home, or in public place.

Manner of injury \_\_\_\_\_  
Nature of injury \_\_\_\_\_

24. Was disease or injury in any way related to occupation of deceased? \_\_\_\_\_

If so, specify \_\_\_\_\_  
(Signed) **Herbert F. Tawarden**, M. D.  
(Address) **712 Medical at Blag**

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.



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