

JAN 9 1935

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

Do not use this space.

43900

1. PLACE OF DEATH

County *Jennison*
Township *Maggaleio*
City *(No)*

Registration District No. *653*
Primary Registration District No. *5871*

File No. *105*
Registered No. *105* (Ward)

2. FULL NAME

Bobbie Joe Randolph

(a) Residence, No. _____ St. _____ Ward _____
(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 <i>m</i>	4. COLOR OR RACE <i>w</i>	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) <i>Single</i>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF _____		
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) <i>Nov 22 1934</i>		
7. AGE YEARS	MONTHS	DAYS
	<i>4</i>	
8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. <i>none</i>		
9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. <i>none</i>		
10. Date deceased last worked at this occupation (month and year) <i>Nov</i>		
11. Total time (years) spent in this occupation _____		

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Jennison Co Mo*

FATHER
13. NAME *Devey Randolph*
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *New Madrid Co Mo*

MOTHER
15. MAIDEN NAME *Lorene William*
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Cape Girardeau Mo*

17. INFORMANT (ADDRESS) *Devey Randolph*

18. BURIAL, CREMATION, OR REMOVAL PLACE *Hayti Mo* DATE *12/22 1934*

19. UNDERTAKER (ADDRESS) *Ray Undertaking*

20. FILED *12-22 1934* *J. W. Rhodes* Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) *12/21 1934*
22. I HEREBY CERTIFY, That I attended deceased from *12/19 1934* to *12/21 1934*
I last saw him alive on *12/21 1934*. Death is said to have occurred on the date stated above, at *11 A* m.

The principal cause of death and related causes of importance were as follows:
Broncho pneumonia
11 A
Other contributory causes of importance: _____

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 *Fract. Cervic* M. D.
(Signed) *Frank A. Lovin*
(Address) *Cumt. College*

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.

100

100

100

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

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH

County Commissar

Registration District No. 653

File No.

Township

Primary Registration District No. 5877

Registered No.

City (No.) St. Ward)

2. FULL NAME

Robbie Joe Randolph

(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 foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX m 4. COLOR OR RACE w 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) S

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 12/21 1934

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

22. I HEREBY CERTIFY, That I attended deceased from

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Nov 22-34

....., 19..... to....., 19.....

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min. 29

I last saw him/her alive on....., 19..... Death is said

to have occurred on the date stated above, at..... m.

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

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

Date of onset

Broncho pneumonia
influenza

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

13. NAME

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

15. MAIDEN NAME

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

17. INFORMANT (ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL PLACE DATE 19.....

19. UNDERTAKER (ADDRESS)

20. FILED 12/22 1934 JWR Rhodes Registrar.

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)....., M. D.

(Address).....

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.
CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is Very important.

SUPPLEMENTARY

FEB 1 1935

5-45900