

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

18574  
Do not use this space.

REC'D JUN 10 1938

1. PLACE OF DEATH

(a) County Jasper Registration District No. 408  
(b) Township E. Jackson Primary Registration District No. 5563A Registered No. ....  
(c) City Carthage (d) Street No. .... St. ....  
(e) Length of residence in city or town where death occurred 56 yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME

Charles Wesley Randall 534  
(a) Residence, No. Route 4 St.  (If nonresident, give city or town and State)  
(Usual place of abode, if no street address, write county or city)

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 Julia  
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) April 19, 1858  
7. AGE YEARS 84 MONTHS 11 DAYS 13 If LESS than 1 day, ..... hrs. or ..... min.  
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Farmer  
9. Industry or business in which work was done, as 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) Mercer Co. Mo. (STATE OR COUNTRY) Mo.

FATHER 13. NAME John Randall  
14. BIRTHPLACE (CITY OR TOWN) Unknown (STATE OR COUNTRY) "

MOTHER 15. MAIDEN NAME Susan Stinnett  
16. BIRTHPLACE (CITY OR TOWN) Unknown (STATE OR COUNTRY) Ohio

17. INFORMANT Mrs. Julia Randall (ADDRESS) Route 4, Carthage

18. BURIAL, CREMATION, OR REMOVAL PLACE Fidelity Cemetery DATE May 8, 1938

19. FUNERAL DIRECTOR (NAME) Rulee Mortuary (ADDRESS) Carthage Mo.

20. FILED May 6, 1938 E. J. McIntire, M.D. Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) May 5, 1938

I HEREBY CERTIFY, that I attended deceased from April 2, 1938, to May 5, 1938  
I last saw him alive on April 4, 1938. Death is said to have occurred on the date stated above, at 10:45 a.m.  
The principal cause of death and related causes of importance were as follows:

Chronic Valvular Heart + Chronic Bright's disease

Date of onset

Other contributory causes of importance: age

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) T. E. Baker, M. D.  
(Address) Carthage Mo.

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,

....., or by .....

Registered Apprentice No....., working under my personal supervision.

Signed

*P.W.K. [Signature]*

Licensed Embalmer No. *814*

P. O. Address *Carthage Mo.*

**Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to do so with the above constitutes grounds for revocation of license.)**

**If this body is not embalmed, above space should be left blank.**

FILL IN ANSWERS TO ALL SPACES  
CHECKED IN RED PENCIL.

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CERTIFICATE OF DEATH

18574  
Do not use this space.

1. PLACE OF DEATH

(a) County Jasper Registration District No. 408  
 (b) Township The Jackson Primary Registration District No. 5263A Registered No. \_\_\_\_\_  
 (c) City \_\_\_\_\_ (d) Street No. \_\_\_\_\_  
 (If death occurred in Hospital or Institution, write its name instead of street and number) St. \_\_\_\_\_  
 (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME

Charles Wesley Raudall  
 (a) Residence, No. \_\_\_\_\_ St.  (If nonresident, give city or town and State)  
 (Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

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

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Apr 9, 1883

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.  
85 0 16

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.  
 9. Industry or business in which work was done, as 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)

FATHER 13. NAME

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

MOTHER 15. MAIDEN NAME

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

17. INFORMANT (ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL

PLACE \_\_\_\_\_ DATE \_\_\_\_\_ 19\_\_

19. FUNERAL DIRECTOR (ADDRESS)

20. FILED May 6, 1938 E. J. McGinty, M.D.  
 Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) May 3, 1938

22. I HEREBY CERTIFY, That I attended deceased from 19\_\_ to 19\_\_

I last saw h. \_\_\_\_\_ 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:

Date of onset

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 \_\_\_\_\_ (Signed) H. E. Baker, M. D.

(Address) Carthage, Mo

SUPPLEMENTARY

WARDS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.

