

1939 MAR 13 1939

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

5114
Do not use this space.

1. PLACE OF DEATH

(a) County.....
(b) Township.....
(c) City..... St. Louis (d) Street No. Homer Phillips Hospital St.
(e) Length of residence in city or town where death occurred 38 yrs. mos. ds. (f) How long in U.S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME 534 Isabell Randall

(a) Residence, No. 819 N 16th St. 25 (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 F 4. COLOR OR RACE C 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Widowed

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Oct. 15, 1867

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
71 4 6

OCCUPATION
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. nil
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) Missouri

FATHER
13. NAME Wash Reynolds

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

MOTHER
15. MAIDEN NAME unknown

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

17. INFORMANT (ADDRESS) Evelyn Hilliard
2601 N Whittier

18. BURIAL, CREMATION, OR REMOVAL PLACE Washington Park DATE Feb 25th '39

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Jas. H. Randle & Son
3133 Bell Avenue

20. FILED JD Budek Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Feb. 21 19 39

22. I HEREBY CERTIFY, That I attended deceased from Feb. 16, 19 39, to Feb. 21, 19 39

I last saw her alive on Feb. 21, 19 39 Death is said to have occurred on the date stated above, at 1:30a.m.

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

Hypertensive heart disease

Date of onset
2/16/39

Other contributory causes of importance
Chronic nephritis

Name of operation _____ Date of _____
What test confirmed diagnosis? clinical Was there an autopsy? NO

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. G. Lyman, M. D.
(Address) 2601 N Whittier

FEB 25 1939

(Licensed Embalmer's Statement on Reverse Side)

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.

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

S. J. Watson
.....
Licensed Embalmer No. *2697*

P. O. Address *2769 Chouteau*

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

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