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.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
DEC 3 8

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 40376

Registration District No. 609 — Primary Registration District No. 4363 — Registrar's No. 139

1. PLACE OF DEATH:

(a) County NEWTON

(b) City or town NEOSHO (If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: 450 E. McKINNEY St (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution (Specify whether years, months or days) In this community 12 YEARS

2. USUAL RESIDENCE OF DECEASED:

(a) State MISSOURI (b) County NEWTON

(c) City or town NEOSHO (If outside city or town limits, write "RURAL")

(d) Street No. 450 E. McKINNEY St (If rural, give location)

(e) If foreign born, how long in U. S. A.? ..... years.

3. (a) PRINT FULL NAME FLORENCE E. RANDOLPH 534

3. (b) If veteran, name war ..... 3. (c) Social Security No. .....

4. Sex FEMALE — 5. Color or race White — 6. (a) Single, widowed, married, divorced Widow

6. (b) Name of husband or wife GRANT RANDOLPH — 6. (c) Age of husband or wife if alive ..... years

7. Birth date of deceased MARCH (Month) 29 (Day) 1874 (Year)

8. AGE: Years 65 — Months 7 — Days 23 — If less than one day ..... hr. ..... min.

9. Birthplace BEDFORD CO. (City, town, or county) PENN. (State or foreign country)

10. Usual occupation AT HOME

11. Industry or business

FATHER
12. Name WILLIAM C. FILLER
13. Birthplace UNKNOWN (City, town, or county) PENN (State or foreign country)

MOTHER
14. Maiden name REBECCA E. SHOEMAKER
15. Birthplace UNKNOWN (City, town, or county) PENN. (State or foreign country)

16. (a) Informant's own signature R. M. Randolph

(b) Address 450 E. McKinney, Neosho, Mo

17. (a) REMOVAL (Burial, cremation, or removal) (b) Date thereof 11-23-1939 (Month) (Day) (Year)

(c) Place: burial or cremation Piqua Ohio

18. (a) Signature of funeral director Carley Thompson

(b) Address Neosho Mo.

19. (a) 11-23-39 (Date received local registrar) (b) Orval R. Sale, M.D. (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month NOVEMBER day 22 year 1939 hour 5 minute 05 P. M.

21. I hereby certify that I attended the deceased from Nov 5, 1939, to Nov 22, 1939; that I last saw her alive on Nov 22, 1939; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Acute Endocarditis	Nov 15
Due to Acute Nephritis	Nov 5
Due to Influenza	Nov 1
Other conditions (Include pregnancy within 3 months of death)	
Major findings: Of operations None	
Of autopsy No	

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) No

(b) Date of occurrence No

(c) Where did injury occur? No (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? No (Specify type of place)

(e) While at work? (e) Means of injury

23. Signature Orval R. Sale M.D. (M. D. or other)

Address ..... Date signed .....

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 6,
District File Number 1239-2574
Date Filed DEC 13 1939

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 Gail K. Gay, Registered Apprentice No. 189 working under my personal supervision.

Signed Carley Thompson

Licensed Embalmer No. 3259

P. O. Address Neosho Mo.

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

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