

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.

SEP 23 1940

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

28912
Do not use this space.

1. PLACE OF DEATH
 (a) County Lafayette Registration District No. 464
 (b) Township Lafayette Primary Registration District No. 4277
 (c) City Odessa (d) Street No. _____ (If death occurred in Hospital or Institution, write its name instead of street and number)
 (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 Hattie J. Randall
 (a) Residence, No. 419 S 4th St 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 F 4. COLOR OR RACE W. 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Married

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) May 14 - 1890

7. AGE YEARS 70 MONTHS 3 DAYS 3 If LESS than 1 day, _____ hrs. or _____ min.

OCCUPATION
 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. housekeeper
 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) Gallatin Mo

FATHER
 13. NAME Wm Jackson Brown
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Missouri

MOTHER
 15. MAIDEN NAME Lucinda Beckwith
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Bloomington Ill

17. INFORMANT R & Randall
 (ADDRESS) Odessa Mo

18. BURIAL, CREMATION, OR REMOVAL Removed
 PLACE St Louis DATE Aug 17 1940

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Long - Gray - Morton Funeral Home

20. FILED Aug 17 1940 Mrs E. M. Gardner
 Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 8-17-1940

22. I HEREBY CERTIFY, That I attended deceased from July 1, 1940 to Aug 17, 1940
 First saw him alive on 8-12-1940. Death is said to have occurred on the date stated above, at 9 a m.
 The principal cause of death and related causes of importance were as follows:
Nephritis Chronic
Endocarditis Chronic
Myocarditis Chronic
 Date of onset _____

Other contributory causes of importance: 1st
Arteriosclerosis Secondary

Name of operation _____ Date of _____
 Was 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) E. B. Nesbet M. D.
 (Address) Odessa Mo

RECEIVED
District Health Officer No. 8,
District File Number
Date Filed 8-29-40

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 Vernon Norton
Licensed Embalmer No. 4125
P. O. Address Linn, Mo

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)
If this body is not embalmed, above space should be left blank.