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

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 36698

Registration District No. 906 Primary Registration District No. 6217 Registrar's No. 84

1. PLACE OF DEATH:

(a) County Wright Twp

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

(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 2 (Specify whether
In this community years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Wright

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

(d) Street No. 0
(If rural, give location)

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

3. (a) PRINT FULL NAME John Calvin Randolph

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex M

5. Color or race W

6. (a) Single, widowed, married, divorced Widowed

6. (b) Name of husband or wife Lydia Randolph

6. (c) Age of husband or wife if alive years

7. Birth date of deceased MAR (Month) 3 (Day) 1870 (Year)

8. AGE: Years 70 Months 4 Days 9 If less than one day hr. min.

9. Birthplace Grove Spring (City, town, or county) Mo (State or foreign country) 0

10. Usual occupation Postal Service 9

11. Industry or business Rural mail carrier

FATHER
12. Name James Randolph 9
13. Birthplace (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Mary Shaddy
15. Birthplace (City, town, or county) (State or foreign country)

16. (a) Informant's own signature Homer Randolph
(b) Address Mansfield Mo

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof July 14-40 (Month) (Day) (Year)
(c) Place: burial or cremation Little Creek Cem

18. (a) Signature of funeral director Gene E Holdren
(b) Address Hartville Mo

19. (a) Oct. 31-40 (Date received local registrar) (b) Ella Claxton (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 12
year 1940 hour 9 minute 30 A.M.

21. I hereby certify that I attended the deceased from July 10, 1940, to July 12, 1940
that I last saw him alive on July 11, 1940
and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Apoplexy	
Chronic Nephritis	
Due to	
Due to 131	
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations
Of autopsy

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)
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? 0 (Specify type of place)
While at work? (e) Means of injury 3

23. Signature F. E. Northey (M.D. or other)
Address Hartville, Mo. Date signed 7/15/40

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 6,
District File Number 1140-2852
Date Filed NOV 23 1940

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 Gene E. Holdren

Licensed Embalmer No. 3865

P. O. Address Hartville, M

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

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