

FILED NOV 11 1942
137

Registration District No.

Primary Registration District No. 5506

Registrar's No. 186

1. PLACE OF DEATH:

(a) County Henry
(b) City or town Clinton mo. R.R. #1
(c) Name of hospital or institution: 1
(If not in hospital or institution, write street number or location)

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

3. (a) PRINT FULL NAME Mrs. Mildred Randolph

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 married

6. (b) Name of husband or wife Clinton Randolph 6. (c) Age of husband or wife if alive years

7. Birth date of deceased Aug 14 1915
(Month) (Day) (Year)

8. AGE: Years 27 Months 1 Days 19 If less than one day hr. min.

9. Birthplace Henry co mo
(City, town, or county) (State or foreign country)

10. Usual occupation House work

11. Industry or business

MOTHER FATHER { 12. Name Henry Braun

{ 13. Birthplace Henry co mo
(City, town, or county) (State or foreign country)

{ 14. Maiden name Leola Mitchell

{ 15. Birthplace Henry co mo
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Henry Braun

(b) Address Clinton mo

17. (a) Burial (b) Date thereof Oct 5 1942
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Englewood

18. (a) Signature of funeral director Chas. L. ...

(b) Address Clinton mo

19. (a) Oct 5 1942 (b) Georgia Kitchen
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State mo (b) County Henry
(c) City or town Clinton mo R.R. #1
(If outside city or town limits, write "RURAL.")

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

(e) Citizen of foreign country? (Yes or No)
If yes, name country.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct day 3
year 1942 hour 1 minute 30 P.M.

21. I hereby certify that I attended the deceased from Sept 30
1942 to Oct 3, 1942
that I last saw her alive on Oct 3, 1942
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Hemorrhage 4 hrs.

Due to 30

Due to Recurrent Thyrotoxic Gaiter
Other conditions: after it was operated 8 years ago
(Include pregnancy within 3 months of death)

Major findings: Of operations PHYSICIAN

Of autopsy 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?

While at work? (Specify type of place) (g) Means of injury

23. Signature P.S. Hallingwood M.D. or other 10/4/42
Address Clinton mo Date signed

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

RECEIVED

District Health Officer No. 7,

District File Number 11-42-1185

Date Filed 11-6-42

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 J. E. Bonner

Licensed Embalmer No. 1891

P. O. Address Clinton

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, fact should be so stated above.