

May 11 '43
WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:
(a) County St. Louis, Missouri
(b) City or town St. Louis, Missouri
(c) Name of hospital or institution: Homer G. Phillips Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: in hospital or institution 2 days (Specify whether
In this community Unknown (Specify whether
years, months or days)

3. (a) PRINT FULL NAME Will Randall
3. (b) If veteran, name World War 3. (c) Social Security No. No
4. Sex Male 5. Color of race C 6. (a) Single, widowed, married, divorced, or other SINGLE
6. (b) Name of husband or wife - 6. (c) Age of husband or wife if alive 41 years 1888
7. Birth date of deceased 4 1 1888 (Month) (Day) (Year)

8. AGE: Years 55 Months 1 Days 0 If less than one day hr. min.
9. Birthplace Hernando MISS. (City, town, or county) (State or foreign country)
10. Usual occupation Laborer

11. Industry or business
12. Name Joe Randall
13. Birthplace MISS. (City, town, or county) (State or foreign country)
14. Maiden name C. Y. Yancy (City, town, or county) (State or foreign country)
15. Birthplace MISS. (City, town, or county) (State or foreign country)
16. (a) Informant Addie Maxwell
(b) Address 919 N. 14th St.
17. (a) Burial (b) Date thereof 5-5-43 (Month) (Day) (Year)
(c) Place: burial or cremation National Cemetery
18. (a) Signature of funeral director [Signature]
(b) Address 3103 Washington
19. (a) MAY 1 1943 (b) J. P. [Signature] (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County [Signature]
(c) City or town St. Louis (If outside city or town limits, write "RURAL")
(d) Street No. 806 N. 13th St. (If rural, give location)
(e) Citizen of foreign country? (Yes or No) (If yes, name country)

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month May day 1, year 1943 hour 3 minute 25 P. M.
21. I hereby certify that I attended the deceased from April 29, 1943 to May 1, 1943 that I last saw him alive on May 1, 1943 and that death occurred on the date and hour stated above.

Immediate cause of death Tuberculous Meningitis
Duration 3 wks.
Due to [Signature]
Due to [Signature]
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?
While at work (Specify type of place) (e) Means of injury
23. Signature S. E. Smith (M. D. or other) Address 2601 N. Whittier Date signed 5/3/43

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 William Claude Gordon

Licensed Embalmer No. 3489

P. O. Address 4575 Aldine

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.