

**1. PLACE OF DEATH:**  
 (a) County Randolph county  
 (b) City or town Jacksonville, Mo. Rural  
 (If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution: None  
 (If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution None  
Entire life (Specify whether years, months or days)

**2. USUAL RESIDENCE OF DECEASED:**  
 (a) State Missouri (b) County Randolph 88  
 (c) City or town Jacksonville, Mo. Rural 0  
 (If outside city or town limits, write "RURAL")  
 (d) Street No. \_\_\_\_\_ (If rural, give location) 0  
 (e) Citizen of foreign country? no (Yes or No) 0  
 If yes, name country \_\_\_\_\_

**3. (a) PRINT FULL NAME** Robert H. Alexander  
 3. (b) If veteran, name war X  
 3. (c) Social Security No. X

4. Sex Male 0 5. Color or race White  
 6. (a) Single, widowed, married, divorced Married  
 6. (b) Name of husband or wife Drusa D. Alexander  
 6. (c) Age of husband or wife if alive 68 years  
 7. Birth date of deceased October 21st 1875  
 (Month) (Day) (Year)

**8. AGE:** Years 71 Months 2 Days 11  
 If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_

**9. Birthplace:** Randolph county Missouri  
 (City, town, or county) (State or foreign country)

**10. Usual occupation:** Farming

**11. Industry or business:** \_\_\_\_\_

MOTHER FATHER

12. Name Wm. N. Alexander  
 13. Birthplace Kentucky  
 14. Maiden name Mattie Alexander  
 15. Birthplace Missouri  
 (City, town or county) (State or foreign country)

**16. (a) Informant:** Mrs. Drusa D. Alexander  
 (b) Address Jacksonville, Missouri

**17. (a) Burial** Philps' Chapel  
 (Burial, cremation, or other) (b) Date thereof 1-14-1947  
 (Month) (Day) (Year)  
 (c) Place: burial or cremation Million & Barkeley Clarence, Mo.

**18. (a) Signature of funeral director:** \_\_\_\_\_  
 (b) Address \_\_\_\_\_

**19. (a) 2-17-47** (Date received local registrar)  
 (b) Leah Williams Louie (Registrar's signature)

**MEDICAL CERTIFICATION**  
 20. DATE OF DEATH: Month January day 12th  
 year 1947 hour 7 minute 15 P.M.  
 21. I hereby certify that I attended the deceased from 1944  
 \_\_\_\_\_, 19\_\_\_\_ to Jan 12, 1947  
 that I last saw him alive on Jan 11, 1947  
 and that death occurred on the date and hour stated above.

Immediate cause of death Chronic myocarditis 2 yrs.  
 Duration \_\_\_\_\_

Due to \_\_\_\_\_  
 Due to \_\_\_\_\_  
 Other conditions Diabetes mellitus 6 yrs  
 (Include pregnancy within 3 months of death)

**PHYSICIAN**  
 Major findings: \_\_\_\_\_  
 Of operations 61  
 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)  
 Means of injury \_\_\_\_\_  
 Signature W. L. Sullivan M.D. (M. D. or other)  
 Address Clarence Mo 12/1/47 Date signed \_\_\_\_\_

RECEIVED  
DISTRICT OFFICE N  
DATE FEB 24  
FEB - 5 - 194

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.....

*C. W. Hawkins*

Licensed Embalmer No. ....

*3498*

P. O. Address.....

*Albino 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, fact should be so stated above.**

Registration District No. *294*

Primary Registration District No. *6007*

Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH:

(a) County *Randolph*  
(b) City or town *Rural*  
(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 \_\_\_\_\_ (Specify whether \_\_\_\_\_)  
In this community \_\_\_\_\_ years, months or days

3. (a) PRINT FULL NAME

*Robert H. Alexander*

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 *m*

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased *oct 2* (Month) *2* (Day) \_\_\_\_\_ (Year)

8. AGE: Years *71* Months \_\_\_\_\_ Days \_\_\_\_\_ If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace \_\_\_\_\_ (City, town, or county) \_\_\_\_\_ (State or foreign country) *MO*

10. Usual occupation \_\_\_\_\_

11. Industry or business \_\_\_\_\_

MOTHER FATHER { 12. Name \_\_\_\_\_  
13. Birthplace \_\_\_\_\_ (City, town, or county) \_\_\_\_\_ (State or foreign country)  
14. Maiden name \_\_\_\_\_  
15. Birthplace \_\_\_\_\_ (City, town, or county) \_\_\_\_\_ (State or foreign country)

16. (a) Informant \_\_\_\_\_ (b) Address \_\_\_\_\_

17. (a) \_\_\_\_\_ (Burial, cremation, or removal) (b) Date thereof \_\_\_\_\_ (Month) (Day) (Year)  
(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_ (b) Address \_\_\_\_\_

19. (a) *Feb 17-47* (Date received local registrar) (b) *Leah Williams Jones* (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State \_\_\_\_\_ (b) County \_\_\_\_\_  
(c) City or town \_\_\_\_\_ (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 \_\_\_\_\_ Day \_\_\_\_\_ Year *1947* hour \_\_\_\_\_ minute \_\_\_\_\_ M.  
21. I hereby certify that I attended the deceased from \_\_\_\_\_ to \_\_\_\_\_, 19\_\_\_\_; that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_; and that death occurred on the date and hour stated above. Immediate cause of death \_\_\_\_\_

Duration \_\_\_\_\_  
Due to \_\_\_\_\_  
Due to \_\_\_\_\_  
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 \_\_\_\_\_ (M. D. or other) \_\_\_\_\_  
Address \_\_\_\_\_ Date signed \_\_\_\_\_

SUPPLEMENTARY

WHILE FERNET USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

2125