S. No. 2
—1/47
5-17-39

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

FEDERAL SECURITY AGENCY
National Office of Vital Statistics

FILED NOV 14 1947

Registration District No. 318

MISSOURI DIVISION OF HEALTH

STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 1003

State File No. 36174

Registrar's No. 10112

1. PLACE OF DEATH:

(a) County

(b) City or town ST LOUIS MISSOURI
(If outside city or town limits, write "RURAL" and name of township)

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

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

2. USUAL RESIDENCE OF DECEASED:

(a) State Arkansas (b) County Benton 999

(c) City or town Rogers 3
(If outside city or town limits, write "RURAL")

(d) Street No. NR - 903 W. Walnut St. 0
(If rural, give location)

(e) Citizen of foreign country? (Yes or No) 2

If yes, name country

3. (a) PRINT FULL NAME James Owen Rand

3. (b) If veteran, name war No

3. (c) Social Security No. 431-50-8876

4. Sex Male

5. Color or race White

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

6. (b) Name of husband or wife Mary Rand

6. (c) Age of husband or wife if alive 65 years

7. Birth date of deceased Sept (Month) - 3 (Day) - 1879 (Year)

8. AGE: Years 68 Months 1 Days 28 If less than one day hr. min.

9. Birthplace Arkansas 1
(City, town, or county) (State or foreign country)

10. Usual occupation Wholesale Grocer

11. Industry or business

FATHER
12. Name Edward Rand
13. Birthplace Arkansas 1
(City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Unknown
15. Birthplace Unknown 9
(City, town, or county) (State or foreign country)

16. (a) Informant Mary Rand
(b) Address Rogers, Ark.

17. (a) Removal (Burial, cremation, or removal) (b) Date thereof 11-2-47 (Month) (Day) (Year)
(c) Place: burial or cremation Rogers, Ark.

18. (a) Signature of funeral director Albert H. Hoppe
(b) Address 4700 Washington Blvd.

19. (a) NOV 2 1947 (Date received local registrar) (b) J. F. Bredeck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month NOV day 1
year 47 hour 5 minute 30 P.M.

21. I hereby certify that I attended the deceased from 10-30, 1947, to 11-1, 1947; that I last saw him alive on 11-1, 1947; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Myocardial Infarction	? Instant
Due to Coronary artery arterio sclerosis	? years.
Due to	
Other conditions (Include pregnancy within 3 months of death)	
Major findings of operation: Autopsy Confirms above.	
~~Of autopsy~~	

PHYSICIAN

Underline the cause of 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? (Specify type of place)

While at work? (e) Means of injury

23. Signature M Bradley (M. D. or other)

Address Barnes Hospital Date signed 11-2-47

Jefferson City Printing Co.

(Licensed Embalmer's Statement on Reverse Side)

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 B W Wilkinson

Licensed Embalmer No. 3575

P. O. Address _____

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.