

FILED NOV 24 1951

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

39604

State File No. 9782  
Registrar's No. 9782

318

1003

BIRTH NO. _____		REG. DIST. NO. _____		PRIMARY REG. DIST. NO. 1003		Registrar's No. 9782	
1. PLACE OF DEATH a. COUNTY _____				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY _____			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis		c. LENGTH OF STAY (In this place) 20 years		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis, 2140			
d. FULL NAME OF HOSPITAL OR INSTITUTION 6316 Tholozan Avenue				f. STREET ADDRESS (If rural, give location) 6316 Tholozan Avenue.			
3. NAME OF DECEASED (Type or Print) a. (First) BERTHA b. (Middle) ELEANOR c. (Last) RANDALL.			4. DATE OF DEATH (Month) (Day) (Year) Nov, 3, 1951.				
5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed 2	8. DATE OF BIRTH Nov. 23, 1870		9. AGE (In years last birthday) 80	IF UNDER 1 YEAR Days	IF UNDER 2 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY At Home		11. BIRTHPLACE (State or foreign country) St. Louis, Missouri.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13a. FATHER'S NAME Henry Pockocke		13b. MOTHER'S MAIDEN NAME Julia Cairns		14. NAME OF HUSBAND OR WIFE Samuel E. Randall.			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Miss. Ory Randall, 6316 Tholozan Avenue			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)  *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (a) Cardio-Vascular - Renal disease Antecedent Causes DUE TO (b) Hypertensive Pneumonia DUE TO (c) Myo Cardial Disorganization II. OTHER SIGNIFICANT CONDITIONS Transition - Nephric Oedema in general						INTERVAL BETWEEN ONSET AND DEATH 4 1/2 1 MO 2 MO 1 year
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION None				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? 4th floor			
22. I hereby certify that I attended the deceased from Nov 19 48, to Nov 2 19 51, that I last saw the deceased alive on Nov 2, 1951, and that death occurred at 9:50 P. m., from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) Sub B. Timmons M.D.			23b. ADDRESS 3734 Jennings Rd			23c. DATE SIGNED 11/4/51	
24a. BURIAL, CREMATION, REMOVAL (Specify) Removal		24b. DATE Nov 5, 1951	24c. NAME OF CEMETERY OR CREMATORY Zion Cemetery		24d. LOCATION (City, town, or county) (State) St. Louis Co., Missouri.		
DATE PREPARED BY LOCAL REG. 10/5		REGISTRAR'S SIGNATURE [Signature]		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Shepard Funeral Home, 1167 Hamilton Ave.			

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

**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 \_\_\_\_\_

Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Student .....  
Student Embalmer

Signed \_\_\_\_\_

*John J. Haines*

Licensed Embalmer No. *4198*

P. O. Address \_\_\_\_\_

*St. Louis 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.