

FILED AUG 30 1954

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **26948**

BIRTH NO. _____ REG. DIST. NO. **137** PRIMARY REG. DIST. NO. **3023** Registrar's No. **11**

1. PLACE OF DEATH a. COUNTY Henry		2. USUAL RESIDENCE (Where deceased lived; if institution: residence before admission) a. STATE Mo. b. COUNTY Henry	
b. CITY OR TOWN Clinton		c. CITY OR TOWN Clinton Mo. 0420	
d. FULL NAME OF HOSPITAL OR INSTITUTION Clinton Gen Hosp.		d. STREET ADDRESS (If rural, give location) RR # 5, Clinton Mo.	
3. NAME OF DECEASED a. (First) May b. (Middle) JANE c. (Last) RANDOLPH		4. DATE OF DEATH (Month) (Day) (Year) Aug 23 1954	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED Widowed	8. DATE OF BIRTH Feb. 8, 1885
9. AGE (In years) (Months) (Days) 69		10. CITIZEN OF WHAT COUNTRY? USA	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife		10b. KIND OF BUSINESS OR INDUSTRY House Keeping	
11. BIRTHPLACE (City and State or Foreign Country) Tebanon Indiana		12. CITIZEN OF WHAT COUNTRY? USA	
13a. FATHER'S NAME Golden B Leet		13b. MOTHER'S MAIDEN NAME Martha Jones	
14. NAME OF HUSBAND OR WIFE Harvey J Randolph		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No.	
16. SOCIAL SECURITY NO. None		17. INFORMANT'S SIGNATURE OR NAME Rayton Randolph Clinton Mo.	
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, athermia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Hypostatic Pneumonia INTERVAL BETWEEN ONSET AND DEATH 3 days ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Cerebral Hemorrhage 6 months DUE TO (c) Malnutrition 8 months II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION 331X	
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?			
22. I hereby certify that I attended the deceased from 7/14/54 , 19 54 , to 8/22/54 , 19 54 ; that I last saw the deceased alive on 8/22/54 , 19 54 , and that death occurred at 3:30 P.M. , from the causes and on the date stated above.			
23a. SIGNATURE (Degree or title) R. S. Haller, M.D.		23b. ADDRESS Clinton Mo.	
23c. DATE SIGNED 8/24/54			
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE Aug. 25-54	
24c. NAME OF CEMETERY OR CREMATORY Englewood Cem.		24d. LOCATION (City, town, or county) (State) Clinton Mo.	
DATE REC'D BY LOCAL REG. Aug 25-54		REGISTRAR'S SIGNATURE Florence Adams	
25. FUNERAL DIRECTOR'S SIGNATURE Dunning Clinton Mo.		ADDRESS	

(Licensed Embalmer's Statement on Reverse Side)

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 Robert L. Dunning

Licensed Embalmer No. 4510

P. O. Address Clinton 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.