

FILED DEC 27 1954

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **40333**

BIRTH NO. _____ REG. DIST. NO. **53** PRIMARY REG. DIST. NO. **3010** Registrar's No. **38**

1. PLACE OF DEATH a. COUNTY Cape Girardeau		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Cape Girardeau	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Cape Girardeau		c. LENGTH OF STAY (In this place) 42 yr	c. CITY OR TOWN Cape Girardeau
d. FULL NAME OF HOSPITAL OR INSTITUTION Family Home, 1302 Bloomfield St		STREET ADDRESS (If rural, give location) 1302 Bloomfield	

3. NAME OF DECEASED (Type or Print) a. (First) Birdie b. (Middle) May c. (Last) Randolph			4. DATE OF DEATH (Month) (Day) (Year) Dec 18 1954
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5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Divorced	8. DATE OF BIRTH Mar-24, 1885	9. AGE (In years last birthday) 69	IF UNDER 1 YEAR Months 8 Days 24	IF UNDER 24 HRS. Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House work	10b. KIND OF BUSINESS OR INDUSTRY none	11. BIRTHPLACE (City and State or Foreign Country) Millersville Mo.	12. CITIZEN OF WHAT COUNTRY? U.S.A
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13a. FATHER'S NAME Reynolds	13b. MOTHER'S MAIDEN NAME Don't know	14. NAME OF HUSBAND OR WIFE None
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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. no	17. INFORMANT'S SIGNATURE OR NAME Mr. Otis Rendolph	ADDRESS Cape Gir. Mo.
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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.	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Coronary Thrombosis		INTERVAL BETWEEN ONSET AND DEATH 16 days
	ANTECEDENT CAUSES Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Coronary Artery Sclerosis		
	DUE TO (c)		
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	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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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) 4201
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
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22. I hereby certify that I attended the deceased from **May 1950** to **Dec 18, 1954**, that I last saw the deceased alive on **Dec 18, 1954**, and that death occurred at **5:40 p.m.**, from the causes and on the date stated above.

23. SIGNATURE John Crowe	(Degree or title) Med. Cape Girardeau, Mo	23b. ADDRESS Dec 29, 1954	23c. DATE SIGNED
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE Dec 21 1954	24c. NAME OF CEMETERY OR CREMATORY Miller Cemetery	24d. LOCATION (City, town, or county) (State) Millersville Mo.
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DATE REC'D BY LOCAL REG. 12-21-54	REGISTRAR'S SIGNATURE T. C. Summers	25. FUNERAL DIRECTOR'S SIGNATURE W. H. Estes	ADDRESS Cape Gir Mo.
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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.....
Signature of Student Embalmer

Signed *E. H. Extra*.....

Licensed Embalmer No. *356*.....

P. O. Address *Cape Gi*.....

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.