

FILED DEC 20 1954

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 40753

BIRTH NO. _____ REG. DIST. NO. 141 PRIMARY REG. DIST. NO. 3025 Registrar's No. 65

1. PLACE OF DEATH
a. COUNTY Howell
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN West Plains
c. LENGTH OF STAY (In this place) 1 Day
d. FULL NAME OF HOSPITAL OR INSTITUTION: Stoll's Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Missouri b. COUNTY Ozark
c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Bakersfield
d. STREET ADDRESS (If rural, give location) _____

3. NAME OF DECEASED (Type or Print)
a. (First) HOMER b. (Middle) EARL c. (Last) RAND

4. DATE OF DEATH (Month) (Day) (Year)
October 6, 1954

5. SEX Male

6. COLOR OR RACE white

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married

8. DATE OF BIRTH Oct. 4, 1899

9. AGE (In years last birthday) 55 IF UNDER 1 YEAR Months Days IF UNDER 1 HR. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Warming

10b. KIND OF BUSINESS OR INDUSTRY farm

11. BIRTHPLACE (State or foreign country) Melbourne, Arkansas

12. CITIZEN OF WHAT COUNTRY? USA

13a. FATHER'S NAME William S. Rand

13b. MOTHER'S MAIDEN NAME Alton Cooper

14. NAME OF HUSBAND OR WIFE Ida Mae Rand

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO

16. SOCIAL SECURITY NO. 431-34-4355

17. INFORMANT'S SIGNATURE OR NAME ADDRESS Mrs. Ida Mae Rand Bakersfield, 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, asthma, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Mediated Epid Thrombosis
ANTECEDENT CAUSES Massive gangrene small intestine
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____
Mesenteric thrombosis
DUE TO (c) _____
II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH
30 hrs.
30 hrs.

19a. DATE OF OPERATION 10 6 54

19b. MAJOR FINDINGS OF OPERATION Massive gangrene small intestine. 5702

20. AUTOPSY? YES NO

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)

21e. INJURY OCCURRED WHILE AT WORK NOT WHILE AT WORK

21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 10 5 54, 1954, to 10 6 54, 1954, that I last saw the deceased alive on 10 6 54, 1954, and that death occurred at 8:50 pm, from the causes and on the date stated above.

23a. SIGNATURE J B Stoll M.D. (Degree or title)

23b. ADDRESS West Plains, Mo

23c. DATE SIGNED 10 9 54

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial

24b. DATE 10/9/54

24c. NAME OF CEMETERY OR CREMATORY Bakersfield Cemetery

24d. LOCATION (City, town, or county) (State) Bakersfield, Missouri

DATE REC'D BY LOCAL REG. 12-17-54

REGISTRAR'S SIGNATURE Beatrice Cook

25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Carter funeral service Salem, Ark.

WRITE PLAINLY—USING UNFAADING 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 _____

Leland Carter

Licensed Embalmer No. *4516*

P. O. Address *Hayes, 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.