

FILED OCT 20 1955

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **34054**

BIRTH NO. _____		REG. DIST. NO. <u>209</u>		PRIMARY REG. DIST. NO. <u>3043</u>		Registrar's No. <u>309</u>			
1. PLACE OF DEATH a. COUNTY <u>Marion</u>				2. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Marion</u>					
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Hannibal</u>		c. LENGTH OF STAY (In this place) <u>2 wks.</u>		c. CITY OR TOWN <u>Hannibal</u>		d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Levering Hospital</u>				e. STREET ADDRESS (If rural, give location) <u>2424 Market St.</u>					
3. NAME OF DECEASED (Type or Print) a. (First) <u>Thomas</u>		b. (Middle) <u>J.</u>		c. (Last) <u>Randall</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>10-11-55</u>			
5. SEX <u>Male</u>		6. COLOR (OR RACE) <u>White</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>		8. DATE OF BIRTH <u>May 18, 1908</u>			
9. AGE (In years last birthday) <u>47</u>		IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 2 HRS. Hours _____ Min. _____					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Self Occupied</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own</u>		11. BIRTHPLACE (City and State or Foreign Country) <u>Hannibal, Missouri</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.</u>			
13a. FATHER'S NAME <u>John Thomas Randall</u>			13b. MOTHER'S MAIDEN NAME <u>Jennie</u>			14. NAME OF HUSBAND OR WIFE <u>Minnie Randall</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>490-07-8680</u>		17. INFORMANT'S SIGNATURE OR NAME <u>Mrs. Minnie Randall, Hannibal, Mo.</u> ADDRESS _____					
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) <u>Pneumonia, left, lower, lobe</u> ANTECEDENT CAUSES DUE TO (b) <u>Toxic myocardiitis</u> <i>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.</i> DUE TO (c) <u>Myocardial insufficiency</u> II. OTHER SIGNIFICANT CONDITIONS <i>Conditions contributing to the death but not related to the disease or condition causing death.</i> <u>4222</u>				INTERVAL BETWEEN ONSET AND DEATH <u>18 days</u> <u>18 days</u> <u>18 days.</u>			
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____				20. AUTOPSY? YES <input type="checkbox"/> NO <input 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) _____		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 <u>Sept. 23</u> , 19 <u>55</u> , to <u>Oct. 11</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>Oct. 11</u> , 19 <u>55</u> , and that death occurred at <u>8 P</u> m., from the causes and on the date stated above.									
23a. SIGNATURE <u>Dr. Carlotta M. D.</u>				23b. ADDRESS <u>707 E. Bdwy, Hannibal, Mo.</u>				23c. DATE SIGNED <u>10-12-55</u>	
24a. BURIAL, CREMA- TION (Specify) <u>Burial</u>		24b. DATE <u>10-13-55</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Mt. Olivet Cemetery</u>		24d. LOCATION (City, town, or county) (State) <u>Hannibal, Missouri</u>			
DATE REC'D BY LOCAL REG. <u>10-13-55</u>		REGISTRAR'S SIGNATURE <u>Paul E. ...</u>			25. FUNERAL DIRECTOR'S SIGNATURE <u>Jack Selwitz - Hannibal</u> ADDRESS _____				

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

RECEIVED OCT 19 1955
MARION CO. HEALTH DEPT.
DATE FILED OCT 19 1955

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 *Jack Schwartz*.....
Licensed Embalmer No. *4*.....
P. O. Address *Hamil*.....

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.