

FRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=60-000950

FILED VS JAN 18 1960

Registration District No. 115-116 Primary Registration District No. 3020 Registrar's No. 12

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <b>FRANKLIN</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MO.</b> b. COUNTY <b>FRANKLIN</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>WASHINGTON</b>		Length of stay in 1b	c. CITY OR TOWN <b>ST. CLAIR,</b> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>ST. FRANCIS HOSP.</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>GRANDVIEW ACERS</b> Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <b>MAGGIE</b> Middle Last <b>RANDALL</b>			4. DATE OF DEATH Month <b>JAN.</b> Day <b>13,</b> Year <b>1960</b>		
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5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>APR. 16, 1883</b>	9. AGE (last birthday) <b>76</b>	IF UNDER 1 YEAR Months <b>8</b> Days <b>9</b>	IF UNDER 24 HR Hours <b></b> Min. <b></b>
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <b>HENDRICKSON, MO.</b>	12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>
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13a. FATHER'S NAME <b>FRANK WOODRUFF</b>	13b. MOTHER'S MAIDEN NAME <b>UNKNOWN</b>	14. NAME OF HUSBAND OR WIFE <b>JOHN RANDALL DEC.</b>
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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) <b>NO</b>	16. SOCIAL SECURITY NO. <b>NONE</b>	17. INFORMANT <b>ROY RANDALL</b> Address <b>ST. CLAIR, MO.</b>
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardio-vascular collapse</b>		INTERVAL BETWEEN ONSET AND DEATH <b>2 hours</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>Post-operative</b>		<b>3 hours</b>
DUE TO (c) <b>Gangrene of Gallbladder + Ventral hernia</b>		<b>7 months + 40 days</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown

19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)
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20c. TIME OF INJURY Hour <b></b> Month, Day, Year <b></b>	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION <b></b> COUNTY <b></b> STATE <b></b>
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21. I attended the deceased from **January 7, 1960** to **January 13, 1960** and last saw her **Jan 13, 1960** alive on **Jan 13, 1960**  
Death occurred at **3:30** p.m. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <b>George C. Richardson, M.D.</b> (Degree or title)	22b. ADDRESS <b>Medical Clinics Union, Mo.</b>	22c. DATE SIGNED <b>Jan 14, 1960</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE <b>JAN. 16, 1960</b>	23c. NAME OF CEMETERY OR CREMATORY <b>HORINE CEMETERY</b>	23d. LOCATION (City, town, or county) (State) <b>RICHWOODS, MO.</b>

24. FUNERAL DIRECTOR <b>KITCHEL FUNERAL HOME ST. CLAIR, MO.</b> ADDRESS <b></b>	25. DATE RECD. BY LOCAL REG. <b>1/14/60</b>	26. REGISTRAR'S SIGNATURE <b>W. S. Subman...</b>
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DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

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**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by \_\_\_\_\_ or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_ working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed Ernest L. Almand

Licensed Embalmer No. 4054  
P. O. Address Union 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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.