

MISSOURI DIVISION OF PUBLIC HEALTH - STANDARD CERTIFICATE OF DEATH

-61-039103
STATE FILE NUMBER

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

AMENDED

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 9631

DATE AMENDED
10/2

INSTEAD OF DOCUMENT

FILED OCT 26 1961

1. PLACE OF DEATH a. COUNTY <u>---</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>---</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. Louis</u>		Length of stay in 1b <u>6 mos.</u>	c. CITY OR TOWN <u>St. Louis</u>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Masonic Home of Mo.</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>6239 Elizabeth</u>
Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			

3. NAME OF DECEASED (Type or print) First <u>Hugh</u> Middle <u>Victor</u> Last <u>Randolph</u>			4. DATE OF DEATH Month <u>October</u> Day <u>16</u> Year <u>1961</u>		
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>1/16/71</u>	9. AGE (last birthday) <u>90</u>	IF UNDER 1 YEAR Months <u>---</u> Days <u>---</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY <u>unknown</u>	11. BIRTHPLACE (City and state or country) <u>Shelbyville, Ill.</u>	12. CITIZEN OF WHAT COUNTRY <u>U. S. A.</u>	

13a. FATHER'S NAME <u>John Randolph</u>		13b. MOTHER'S MAIDEN NAME <u>Charity Fields</u>		14. NAME OF HUSBAND OR WIFE <u>Lucy May White</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>---</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT <u>Masonic Home of Mo.</u> Address <u>Carl S. Steinbock, Dept</u>	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:			INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) <u>Uremia</u>			<u>3 Mo.</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>Chronic Nephrosis</u>		<u>unknown</u>
	DUE TO (c) <u>Generalized arteriosclerosis</u>		<u>unknown</u>

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>446X</u>			PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		
--	--	--	--	--	--

19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" 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.) <u>---</u>
---	---	--

20c. TIME OF INJURY Hour <u>---</u> Month, Day, Year <u>---</u> a.m. <u>---</u> p.m. <u>---</u>	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.) <u>---</u>	20f. CITY, TOWN, OR LOCATION <u>---</u>	COUNTY <u>---</u>	STATE <u>---</u>
---	--	--	--	-------------------	------------------

21. I attended the deceased from <u>4/21/61</u> to <u>10/16/61</u> and last saw ^{DECEASED} him alive on <u>10/16/61</u> Death occurred at <u>4:35 PM</u> m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>Harold E. Walters M.D.</u>		22b. ADDRESS <u>3720 Washington St. St. Louis</u>	22c. DATE SIGNED <u>10-18-61</u>

23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>10/19/61</u>	23c. NAME OF CEMETERY OR CREMATORY <u>OAK GROVE CEM.</u>	23d. LOCATION (City, town, or county) (State) <u>St. Charles, Mo.</u>
--	------------------------------	---	--

24. FUNERAL DIRECTOR <u>Arthur C. Baue</u>	ADDRESS <u>St. Charles, Mo.</u>	25. DATE RECD. BY LOCAL REG. <u>OCT 18 1961</u>	26. REGISTRAR'S SIGNATURE <u>Carl Smith M.D.</u>
---	------------------------------------	--	---

MEDICAL CERTIFICATION

DOCUMENT

BY AFFIDAVIT OF

SHOULD BE KEPT

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: David P. Bane

Licensed Embalmer No. 5060

P. O. Address S. J. Chas

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.