URI DIVISION OF HEALTH — STANDARD CERTIFICATE OF DEATH

=60=017251
STATE FILE NUMBER

FILED VS MAY 2 1960

Registration District No. ______ Primary Registration District No. ______ Registrar's No. 2 4216

ENDED

1. PLACE OF DEATH a. COUNTY	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis — Length of stay in 1b: 34 Years	c. CITY OR TOWN St. Louis — Inside Limits Yes [X] No [ ]
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Marion Hospital — Inside Limits Yes [X] No [ ]	d. STREET ADDRESS (If outside, give location) 6220 Alabama — Reside on Farm Yes [ ] No [X]

3. NAME OF DECEASED (Type or print)	First	Middle	Last	4. DATE OF DEATH	Month	Day	Year
	JAMES	F.	RANDOLPH		4	16	60

5. SEX	6. COLOR OR RACE	7. Married / Never Married / Widowed / Divorced	8. DATE OF BIRTH	9. AGE (last birthday)	IF UNDER 1 YEAR Months / Days	IF UNDER 24 HR Hours / Min.
Male	White	Married [X] Never Married [ ] Widowed [ ] Divorced [ ]	3/30/81	79		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country)	12. CITIZEN OF WHAT COUNTRY
Blacksmith	Retired	Ellington, Mo.	U.S.A.

13a. FATHER'S NAME	13b. MOTHER'S MAIDEN NAME	14. NAME OF HUSBAND OR WIFE
John Randolph	Sarah Weems	Elizabeth Randolph

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT Address
No		Dorothy Tucker, 3325 Wisconsin

MEDICAL CERTIFICATION

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) Cardio Vascular Heart disease — 3

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.

DUE TO (b) 422.1

DUE TO (c) Tumor Prostate Gland — Feb 1-1960

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. [ ] Yes [ ] No [ ] Unknown

19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]

20a. ACCIDENT [ ] SUICIDE [ ] HOMICIDE [ ]

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year

20d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]

20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

20f. CITY, TOWN, OR LOCATION COUNTY STATE

21. I attended the deceased from July 10 - 1959, to April 16 1960 and last saw him alive on April 16-1960

Death occurred at 2:30 P.M. m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) H. F. Moore M.D. — 22b. ADDRESS 917-5018 — 22c. DATE SIGNED 4-18-1960

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City, town, or county) (State)
Removal	4/20/60	Ellington Cem.	Ellington, Mo.

24. FUNERAL DIRECTOR ADDRESS	25. DATE RECD. BY LOCAL REG.	26. REGISTRAR'S SIGNATURE
McLaughlin's, 2301 Lafayette	APR 18 1960	Earl Smith, M.D.

(Licensed Embalmer's Statement on Reverse Side)

BY AFFIDAVIT OF ... DOCUMENT "A" Underlying Cause ...

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_____

Licensed Embalmer No._____

P. O. Address_____

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to co
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.