

Health, Welfare
Public Service

2207

THE DIVISION OF HEALTH OF MASSACHUSETTS
STANDARD CERTIFICATE OF DEATH

FILED JAN 22 1958

STATE FILE NUMBER

Registration District No. 267 Primary Registration District No. 3049 Registrar's No. 49

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-57

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| 1. PLACE OF DEATH a. COUNTY <u>Cambrid</u> | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Massachusetts</u> b. COUNTY <u>Cambrid</u> | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Houghton</u> | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | c. CITY OR TOWN <u>Steele</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |
| c. FULL NAME OF HOSPITAL OR INSTITUTION <u>Musical Hoop</u> | | Length of stay in 1b | d. STREET ADDRESS (If outside, give location) <u>E Main</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |

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| 3. NAME OF DECEASED (Type or print) First <u>Season</u> Middle <u>S</u> Last <u>Logue</u> | | | 4. DATE OF DEATH Month <u>1</u> Day <u>1</u> Year <u>58</u> | | |
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| 5. SEX <u>F</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>12-9-1936</u> | 9. AGE (In years last birthday) <u>1</u> | IF UNDER 1 YEAR Months <u>0</u> Days <u>23</u> | IF UNDER 24 HRS. Hours <u></u> Min. <u></u> |
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| 10a. USUAL OCCUPATION (Give kind of work done during most of last year, or even if retired) <u>child</u> | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (City and state or country) <u>Agusta MA</u> | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> |
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| 13a. FATHER'S NAME <u>Benjamin Logue</u> | 13b. MOTHER'S MAIDEN NAME <u>Alicie Lorraine Kilgore</u> | 14. NAME OF HUSBAND OR WIFE |
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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) <u>No</u> | 16. SOCIAL SECURITY NO. | 17. INFORMANT <u>Benjamin Logue</u> Address <u>Steele Dr</u> |
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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) <u>Menigitis, type unknt.</u> | | INTERVAL BETWEEN ONSET AND DEATH <u>1 dx</u> |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) _____ DUE TO (c) _____ | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |

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| 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 _____ a.m. _____ p.m. _____ | 20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE 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 <u>Steele, Me</u> | COUNTY _____ | STATE _____ |
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| 21. ^{31W} attended the deceased from <u>1 JAN 58</u> to <u>1 JAN 58</u> and last saw ^{her} alive on <u>1 JAN 58</u> Death occurred at _____ m on the date stated above; and to the best of my knowledge, from the causes stated. |
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| 22a. SIGNATURE <u>E P Taylor M.D.</u> (Degree or title) | 22b. ADDRESS <u>Steele, Me</u> | 22c. DATE SIGNED <u>1 Jan 58</u> |
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| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u> | 23b. DATE <u>1-3-58</u> | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION (City, town, or county) (State) <u>Agusta MA</u> |
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| 24. FUNERAL DIRECTOR <u>Sumner Smith Co</u> ADDRESS <u>Steele</u> | 25. DATE RECD. BY LOCAL REG. <u>1-8-58</u> | 26. REGISTRAR'S SIGNATURE <u>John W. Corman</u> |
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(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

Doctor, coroner, etc. must use only standard nomenclature in their reports. No symptoms were observed. All diseases in Part I must be causally related.

1-26-58

JAN 21 1958

PEMISCOT COUNTY HEALTH DEPARTMENT
COURTHOUSE PHONE 79
CARUTHERSVILLE, MO.

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 *Robert W. Jones*

Licensed Embalmer No. *4732*
P. O. Address *Stale 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.