URI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

FILED VS SEP 18 1959

59–033029
STATE FILE NUMBER

Registration District No. 200 Primary Registration District No. 3041 Registrar's No. 157

1. PLACE OF DEATH
a. COUNTY: MACON
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: MACON
Length of stay in 1b: 2 HRS
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION: SAMARITAN HOSP
Inside Limits: Yes ☒ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: ILL
b. COUNTY: ROCK ISLAND
c. CITY OR TOWN: EAST MOLINE ILL
Inside Limits: Yes ☒ No ☐
d. STREET ADDRESS (If outside, give location): 325 24th AVE
Reside on Farm: Yes ☐ No ☒

3. NAME OF DECEASED (Type or print): First MARY Middle ALICE Last RAMSDALE
4. DATE OF DEATH: Month SEPT Day 12 Year 1959
5. SEX: FEMALE
6. COLOR OR RACE: WHITE
7. Married ☐ Never Married ☐ Widowed ☒ Divorced ☐
8. DATE OF BIRTH: APRIL 30 1871
9. AGE (last birthday): 88
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HR: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEWIFE
10b. KIND OF BUSINESS OR INDUSTRY: HOUSEWIFE
11. BIRTHPLACE (City and state or country): MISSOURI
12. CITIZEN OF WHAT COUNTRY: US
13a. FATHER'S NAME: CHATMAN JOHNSON
13b. MOTHER'S MAIDEN NAME: UNKNOWN
14. NAME OF HUSBAND OR WIFE: ~~CHAS~~ UNKNOWN
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO
(If yes, give war or dates of service): NO
16. SOCIAL SECURITY NO.: NONE
17. INFORMANT: CARL RAMSDALE Address: CLARENCE MO

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Shock, primary, irreversible — INTERVAL BETWEEN ONSET AND DEATH: 2 hours
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b): fracture, intertrochanteric, left femur — 3 hours
DUE TO (c):
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 ☒
20a. ACCIDENT ☒ SUICIDE ☐ HOMICIDE ☐
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) Fell off concrete steps of porch
20c. TIME OF INJURY Hour 7:00 a.m. p.m. Month, Day, Year Sept 12, 1959
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.): Home
20f. CITY, TOWN, OR LOCATION: RFD 3 Clarence COUNTY: Shelby STATE: Missouri

21. I attended the deceased from Sept 12, 1959, to Sept 12, 1959 and last saw her/him alive on Sept 12, 1959
Death occurred at 10:00 p.m. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title): Carl T. Rinker M.D.
22b. ADDRESS: Macon, Missouri
22c. DATE SIGNED: Sept 14, 1959

23a. BURIAL, CREMATION, REMOVAL (Specify): REMOVAL
23b. DATE: 9-16-59
23c. NAME OF CEMETERY OR CREMATORY: MEMORIAL PARK CEMETERY
23d. LOCATION (City, town, or county) (State): ROCK ISLAND ILL
24. FUNERAL DIRECTOR: GREENING — ADDRESS: CLARENCE MO
25. DATE RECD. BY LOCAL REG.: 9/15/59
26. REGISTRAR'S SIGNATURE: Ruth McNeely

(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT BY AFFIDAVIT OF

Date Filed .....

OCT 6 1959

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by m

or by _____, Student Embalmer No._____

working under my personal supervision.

Student_____
Signature of Student Embalmer

Signed Charles V. Green

Licensed Embalmer No. 4625

P. O. Address Clarence

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