

FEDERAL DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-035522

FILED VS OCT 30 1959

Registration District No. 71 Primary Registration District No. 3012 Registrar's No. 100

STATE FILE NUMBER

| | | | |
|--|--|---|---|
| 1. PLACE OF DEATH a. COUNTY <u>Clay</u> | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Clay</u> | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Excelsior Springs</u> | | Length of stay in 1b <u>40 years</u> | c. CITY OR TOWN <u>Excelsior Springs</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>630 Cannon</u> | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | d. STREET ADDRESS (If outside, give location) <u>630 Cannon</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>Elizabeth</u> Middle <u>Jane</u> Last <u>Riding</u> | | | 4. DATE OF DEATH Month <u>October</u> Day <u>19</u> Year <u>1959</u> | | | | |
| 5. SEX <u>Female</u> | 6. COLOR OR RACE <u>Negro</u> | 7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH <u>12-12-1891</u> | 9. AGE (last birthday) <u>67</u> | IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u> | IF UNDER 24 HR Hours <u> </u> Min. <u> </u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (City and state or country) <u>Camden, Missouri</u> | | 12. CITIZEN OF WHAT COUNTRY <u>USA</u> | |
| 13a. FATHER'S NAME <u>Will Simpson</u> | | 13b. MOTHER'S MAIDEN NAME <u>Lucy Simpson</u> | | 14. NAME OF HUSBAND OR WIFE <u>Roy Riding</u> | | | |
| 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. <u>331-01-9121</u> | | 17. INFORMANT Address <u>Mo. Evelyn James, 620 Cannon, Excelsior Spgs.</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: | | INTERVAL BETWEEN ONSET AND DEATH |
| IMMEDIATE CAUSE (a) <u>Uremia</u> | | <u>sev. mos.</u> |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. | DUE TO (b) <u>diabetes mellitus (severe)</u> | <u>10 yrs.</u> |
| | DUE TO (c) <u>arteriosclerotic heart disease</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>amputation of both legs-8 and 6 yrs. ago</u> | | 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 |

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|---|---|--|---|
| 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.) | |
| 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.) | 20f. CITY, TOWN, OR LOCATION COUNTY STATE |

21. I attended the deceased from 1949 to 10/19/59 and last saw her alive on 10/19/59
Death occurred at 7:30 a.m. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title)
M. D., Excelsior Springs, Mo.

22b. ADDRESS
Excelsior Springs, Mo.

22c. DATE SIGNED
10/20/59

| | | | |
|---|--------------------------------|--|---|
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | 23b. DATE <u>10-22-1959</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>Elmwood</u> | 23d. LOCATION (City, town, or county) (State) <u>Excelsior Springs, Missouri</u> |
| 24. PREPARED BY <u>Prepared Funeral Home, Inc. Excelsior Springs, Missouri</u> | | 25. DATE RECD. BY LOCAL REG. <u>10/24/59</u> | REGISTRAR'S SIGNATURE <u>Pauline Hutchings</u> |

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

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

Ralph Van Ledingham

Licensed Embalmer No. 4009

Robert Frings

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.