

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

LED VS JAN 26 1960

60-000982

STATE FILE NUMBER

Registration District No. 120 Primary Registration District No. _____ Registrar's No. 6

1. PLACE OF DEATH a. COUNTY <u>Genesee</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>NY</u> b. COUNTY <u>Genesee</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Albany</u>		Length of stay in 1b <u>2 WKS.</u>	c. CITY OR TOWN <u>Statenburg</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>Albany Memorial Hospital</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>N. Alonthus Ave</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Middle Last <u>Mr. Donald S. Hawthorne</u>			4. DATE OF DEATH Month Day Year <u>Jan. 14 - 1960</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>W</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>3/6/1888</u>	9. AGE (last birthday) <u>71</u>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) <u>Hotel Manager of 40 years</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Hotels</u>	11. BIRTHPLACE (City and state or country) <u>Port Washington, Ohio</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13a. FATHER'S NAME <u>Dr. J. A. Hawthorne</u>		13b. MOTHER'S MAIDEN NAME <u>Melissa Gost</u>		14. NAME OF HUSBAND OR WIFE <u>Elice Hawthorne</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>487-050-5947A</u>	17. INFORMANT <u>Mrs. Elice Hawthorne</u>	Address <u>Statenburg, NY</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>Branchitis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>Years</u> <u>Years</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.)	DUE TO (b) <u>Emphysema</u>	
	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. <input type="checkbox"/> Yes <input 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 Month, Day, Year a.m. p.m.		
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 12-31-59 to 1-14-60 and last saw ^{him} alive on 1-14-60
 Death occurred at 7:45 P.M. JAN. 14, 1960 on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <u>Frank A. Rose M.D.</u>	(Degree or title)	22b. ADDRESS <u>Albany - NY</u>	22c. DATE SIGNED <u>1-10-60</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE <u>1-17-60</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Hugh Ridge</u>	23d. LOCATION (City, town, or county) (State) <u>Statenburg, Genesee Co. NY</u>
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24. FUNERAL DIRECTOR <u>Phillips Montoury, Statenburg, NY</u>	ADDRESS	25. DATE RECD. BY LOCAL REG. <u>1-18-1960</u>	26. REGISTRAR'S SIGNATURE <u>Mrs. L. W. Bare</u>
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DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

JAN 27 1980

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 Leroy F. Phillips

Licensed Embalmer No. 189

P. O. Address Stonewall

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.