

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=60-001314

FILED VS FEB 2 1960

STATE FILE NUMBER

Registration District No. 144 Primary Registration District No. 3025 Registrar's No. 17

DED

1. PLACE OF DEATH a. COUNTY <u>Worcester</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mass.</u> b. COUNTY <u>Worcester</u>			
b. CITY (If outside corporate limits give TOWNSHIP only) OR TOWN <u>West Plains</u>		Length of stay in 1b <u>4 yrs</u>		c. CITY OR TOWN <u>West Plains</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>725 Worcester</u>			Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (if outside, give location) <u>725 Worcester</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Robert L.</u> Middle <u>Ellens</u> Last <u></u>				4. DATE OF DEATH Month <u>1</u> Day <u>17</u> Year <u>1960</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <u>11-29-92</u>	9. AGE (last birthday) <u>67</u>	IF UNDER 1 YEAR Months <u></u> Days <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>Retired Salesman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u></u>		11. BIRTHPLACE (City and state or country) <u>Duxon Mass</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13a. FATHER'S NAME <u>R.C. Collins</u>			13b. MOTHER'S MAIDEN NAME <u>Josephine Carroll</u>		14. NAME OF HUSBAND OR WIFE <u>Ann K. Collins</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, or unknown)		16. SOCIAL SECURITY NO. <u>420 Mrs E.L. Collins, West Plains Mass</u>		17. INFORMANT Address <u></u>			
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>Suffocation as result of flames</u> DUE TO (b) <u>in fire at home</u> DUE TO (c) <u></u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.						INTERVAL BETWEEN ONSET AND DEATH	
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	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input checked="" 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.) <u>Rubber cushions in chair burning</u>					
20c. TIME OF INJURY Hour <u></u> a.m. <u></u> p.m. <u></u> Month, Day, Year <u></u>		20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>725 Worcester</u>	20f. CITY, TOWN, OR LOCATION <u>West Plains</u>	COUNTY <u>Worcester</u>	STATE <u>Mass</u>	
21. I attended the deceased from <u>about 4:30 P.</u> to <u></u> and last saw her/him alive on <u></u> . Death occurred at <u></u> m on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) <u>Beatrice Cook Registrar</u>				22b. ADDRESS <u>West Plains Mass</u>		22c. DATE SIGNED	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>1-20-60</u>		23b. DATE <u>1-20-60</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Oak Lawn</u>		23d. LOCATION (City, town, or county) (State) <u>West Plains Mass</u>	
24. FUNERAL DIRECTOR <u>Chester's West Plains</u>				25. DATE RECD. BY LOCAL REG. <u>MS 1-26-60</u>		26. REGISTRAR'S SIGNATURE <u>Beatrice Cook</u>	

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1961 7 2 844 SA

MAR 1 1960

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 A. A. Roberts

Licensed Embalmer No. 343

P. O. Address West Ha

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