

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-002468

FILED VS. JAN 21 1960 200

Registration District No. _____ Primary Registration District No. _____ Registrar's No. 2 STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <u>Macon</u> b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Hudson Twp</u> Length of stay in 1b <u>16 yr 1mo</u> c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Still-Hildreth Osteopathic Hospital</u> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Michigan</u> b. COUNTY <u>Lenawee</u> c. CITY OR TOWN <u>Adrain</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> d. STREET ADDRESS (If outside, give location) <u>330 Michigan Ave</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Louise</u> Middle _____ Last <u>Ladd</u>			4. DATE OF DEATH Month <u>Jan</u> Day <u>2</u> Year <u>1960</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</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>11/16/1873</u>	9. AGE (last birthday) <u>86</u>	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) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY _____		11. BIRTHPLACE (City and state or country) <u>Adrian, Michigan</u>	12. CITIZEN OF WHAT COUNTRY _____	
13a. FATHER'S NAME <u>LaFayette Ladd</u>			13b. MOTHER'S MAIDEN NAME <u>Livinda (unknown)</u>		14. NAME OF HUSBAND OR WIFE _____	
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>Unknown</u>		17. INFORMANT <u>J.P. Libs</u> Address <u>Adrian, Michigan</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>Medullary Failure</u> DUE TO (b) <u>Thrombotic Encephalomalacia</u> DUE TO (c) <u>Arteriosclerosis</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 checked="" type="checkbox"/> No <input type="checkbox"/> Unknown	
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 _____ a.m. _____ p.m. Month, Day, Year		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.)		20f. CITY, TOWN, OR LOCATION _____ COUNTY _____ STATE _____
21. I attended the deceased from <u>December 6, 1959</u> to <u>Jan 2, 1960</u> and last saw her <u>live</u> on <u>Jan 2, 1960</u> Death occurred at <u>12:25</u> <u>Pm</u> on the date stated above, and to the best of my knowledge, from the causes stated.						
22a. SIGNATURE <u>Hary S. Stell D.O.</u> (Degree or title)			22b. ADDRESS <u>Macon, Missouri</u>		22c. DATE SIGNED <u>1/2/60</u>	
23a. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>1/6/1960</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Oakwood Cem.</u>		23d. LOCATION (City, town, or county) (State) <u>Adrian Michigan</u>	
24. FUNERAL DIRECTOR <u>Everiss Funeral Home</u> ADDRESS <u>Adrian Mich.</u>			25. DATE RECD. BY LOCAL REG. <u>1/2/60</u>		26. REGISTRAR'S SIGNATURE <u>Cuth McNeely</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 _____ or by _____, Student Embalmer No. _____ working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Charles L. Hutton

Licensed Embalmer No. 4577

P. O. Address Macon,

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