URI DIVISION OF HEALTH — STANDARD CERTIFICATE OF DEATH

FILED VS FEB 25 1960

60-008576

STATE FILE NUMBER

Registration District No. _____ Primary Registration District No. _____ Registrar's No. 2 1899

NDED

DOCUMENT

BY AFFIDAVIT OF

MEDICAL CERTIFICATION

1. PLACE OF DEATH
a. COUNTY
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: St. Louis,
Length of stay in 1b: 9 days
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION: St.Louis-Little Rock Hospitals Inc.
Inside Limits: Yes ☒ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Florida b. COUNTY: PALM BEACH
c. CITY OR TOWN: Delray Beach,
Inside Limits: Yes ☒ No ☐
d. STREET ADDRESS (If outside, give location): Box 1625
Reside on Farm: Yes ☐ No ☒

3. NAME OF DECEASED (Type or print): First: James Middle: Roderick Last: MacDonald

4. DATE OF DEATH: Month: Feb. Day: 16, Year: 1960

5. SEX: Male
6. COLOR OR RACE: White
7. Married ☐ Never Married ☐ Widowed ☒ Divorced ☐
8. DATE OF BIRTH: Dec.25,1870
9. AGE (last birthday): 89 yrs.
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): Telegrapher
10b. KIND OF BUSINESS OR INDUSTRY: Railroad
11. BIRTHPLACE (City and state or country): BRYSON, QUEBEC CANADA
12. CITIZEN OF WHAT COUNTRY: USA

13a. FATHER'S NAME: UNKNOWN MACDONALD
13b. MOTHER'S MAIDEN NAME: UNKNOWN McDOUGAL
14. NAME OF HUSBAND OR WIFE: NELLIE HELEN MACDONALD

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service): NONE
16. SOCIAL SECURITY NO.: NONE
17. INFORMANT: BERENICE M. GILLASPY 914 S.W. 28th Address BOYNTON BEACH FLA.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Carcinoma of Pancreas
INTERVAL BETWEEN ONSET AND DEATH: few months
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b):
DUE TO (c): 157+

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a): Arteriosclerotic Heart Disease

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.)
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year
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.)
20f. CITY, TOWN, OR LOCATION COUNTY STATE

21. I attended the deceased from Feb. 8,1960, to Feb. 16,1960 and last saw her/him alive on Feb. 16,1960
Death occurred at 10/P.M., m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE: R B Hanson (Degree or title): M.D.
22b. ADDRESS: 1755 South Grand Blvd.,
22c. DATE SIGNED: 2-17-60

23a. BURIAL, CREMATION, REMOVAL (Specify): REMOVAL
23b. DATE: 2-19-1960
23c. NAME OF CEMETERY OR CREMATORY: VALHALLA CEM.
23d. LOCATION (City, town, or county) (State): ST. LOUIS COUNTY Mo.

24. FUNERAL DIRECTOR: Pfitzinger Mortuary ADDRESS: 331 So. Kirkwood Rd., Kirkwood, Mo.
25. DATE RECD. BY LOCAL REG.: FEB 18 1960
26. REGISTRAR'S SIGNATURE: Hoard Smith, M.D.

(Licensed Embalmer's Statement on Reverse Side)

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 Ben E. Hoffman

Licensed Embalmer No. 4366

P. O. Address St Louis Co

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