

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-035758

FILED VS SEP 21 1960

Registration District No. 290 Primary Registration District No. _____ Registrar's No. 125

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <u>Pulaski</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Ohio</u> b. COUNTY <u>Cuyahoga</u>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Cullen Township</u>		Length of stay in 1b	c. CITY OR TOWN <u>Cleveland</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>Rt 66 on spur to Ft Wood,</u>			100 yds off	d. STREET ADDRESS (If outside, give location) <u>1642 E. 77th Street</u>		
3. NAME OF DECEASED (Type or print) First <u>Jimmy</u> Middle <u>Lee</u> Last <u>Ellington</u>			4. DATE OF DEATH Month <u>September</u> Day <u>2</u> Year <u>1960</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Negroid</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>1/14/42</u>	9. AGE (last birthday) <u>18</u>	IF UNDER 1 YEAR Months _____ Days _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Student</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>***</u>	11. BIRTHPLACE (City and state or country) <u>Shelby N C</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13a. FATHER'S NAME <u>Willie Ellington</u>		13b. MOTHER'S MAIDEN NAME <u>Elizabeth (Unknown)</u>		14. NAME OF HUSBAND OR WIFE _____		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <u>Yes 21 Mar 60 to date</u>		16. SOCIAL SECURITY NO. <u>301-36-5487</u>	17. INFORMANT <u>Robert L Rippee, Ft Leonard Wood, Mo.</u>			
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 <u>Immediate</u>	
IMMEDIATE CAUSE (a) <u>Intracranial Hemorrhage</u>						
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Skull Fracture</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) <u>Compound Fracture - Tibia & Fibia Bilateral</u> <u>U/A</u>				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 checked="" type="checkbox"/> NO <input 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>Struck by automobile</u>				
20c. TIME OF INJURY <u>1145</u>	Hour <u>4:00</u> p.m.	Month, Day, Year <u>9/2/60</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>Highway</u>		20f. CITY, TOWN, OR LOCATION <u>Pulaski, Mo.</u>		COUNTY _____ STATE _____
21. I attended the deceased from <u>ON Sept 2, 1960</u> to _____ and last saw her/him alive on _____ Death occurred at <u>1145</u> p.m. on the date stated above, and to the best of my knowledge, from the causes stated.						
22a. SIGNATURE OF FUNERAL DIRECTOR <u>George F. Scofield, Capt. MC</u>			22b. ADDRESS <u>US Army Hospital Ft Leonard Wood, Mo.</u>		22c. DATE SIGNED _____	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	23b. DATE <u>Sept 5 1960</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Unknown</u>	23d. LOCATION (City, town, or county) <u>Cleveland Ohio</u>		(State) _____	
24. FUNERAL DIRECTOR ADDRESS <u>HEDGES FUNERAL HOMES INC CROCKER MO</u>			25. DATE RECD. BY LOCAL REG. <u>9-5-60</u>	26. REGISTRAR'S SIGNATURE <u>Genta P. Anderson</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

Clarence Moss

Licensed Embalmer No. 4896

P. O. Address Waverly

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.