

FILED JAN 3 1949

Registration District No. 1944

Primary Registration District No. 1002

1. PLACE OF DEATH:

(a) County Jackson  
 (b) City or town Keokuk  
 (c) Name of hospital or institution:  
Howe 3715 Oakley  
 (If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution 10 yrs  
 In this community 10 yrs  
 years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Jackson  
 (c) City or town Keokuk  
 (d) Street No. 3715 OAKLEY  
 (If rural, give location)  
 (e) Citizen of foreign country? no (Yes or No)  
 If yes, name country 0

3. (a) PRINT FULL NAME SARAH RIDGWAY

3. (b) If veteran, name war NONE 3. (c) Social Security No. NONE

4. Sex FE 5. Color or race NEGRO 6. (a) Single, widowed, married WIDOWED  
 6. (b) Name of husband or wife NONE 6. (c) Age of husband or wife if alive 21 years

7. Birth date of deceased APR 13 1927  
 (Month) (Day) (Year)

8. AGE: Years 51 Months 8 Days 0  
 If less than one day hr. min.

9. Birthplace COLUMBIA MISSOURI  
 (City, town, or county) (State or foreign country)

10. Usual occupation DOMESTIC

11. Industry or business

MOTHER FATHER  
 { 12. Name WILL RIDGWAY  
 { 13. Birthplace MO  
 { 14. Maiden name BETTIE GORDON  
 { 15. Birthplace MO  
 (City, town, or county) (State or foreign country)

16. (a) Informant NANCY SMITH  
 (b) Address 3715 TORRING KEOKUK

17. (a) BURIAL (b) Date thereof 12-18-43  
 (Burial, cremation, or removal) (Month) (Day) (Year)  
 (c) Place: burial or cremation HIGHLAND

18. (a) Signature of funeral director Elyon & Greenleaf  
 (b) Address 1819 E. 15 KEOKUK  
 19. (a) 12-17-43 (b) D. E. Brown  
 (Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 12 day 13 - 43  
 year hour minute M.  
 21. I hereby certify that I attended the deceased from 12-12-43  
 to 12-12 1943  
 that I last saw her alive on 12-12 1943

and that death occurred on the date and hour stated above.  
 Immediate cause of death Cerebral Hemorrhage  
 Due to Hypertension  
 Due to 82w  
 Other conditions none  
 (Include pregnancy within 3 months of death)

Duration

PHYSICIAN

Major findings:  
 Of operations none  
 Of autopsy no

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:  
 (a) Accident, suicide, or homicide (specify) no  
 (b) Date of occurrence  
 (c) Where did injury occur? (City or town) (County) (State)  
 (d) Did injury occur in or about home, on farm, in industrial place, in public place?

23. Signature T. D. Rankin (Specify type of place) (e) Means of injury  
 (M. D. or other)  
 Address 2206 E. 18th St Date signed

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

**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.....

....., Registered Apprentice No. ....  
working under my personal supervision.

Signed..... *Wm G. J. Lyons*

Licensed Embalmer No. .... *2211*

P. O. Address. .... *1819 E. 15*

**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 this body is not embalmed, fact should be so stated above.**