

FILED JAN 5 1944

Registration District No. 264

Primary Registration District No. 6009

Registrar's No.

1. PLACE OF DEATH:

(a) County: Randolph

(b) City or town: Russell, Salt River
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: _____
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution: _____ (Specify whether)

In this community: _____ years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State: Missouri (b) County: Randolph

(c) City or town: Rural
(If outside city or town limits, write "RURAL")

(d) Street No. _____ (If rural, give location)

(e) Citizen of foreign country? No (Yes or No)
If yes, name country: _____

3. (a) PRINT FULL NAME: Nina Ridgway

3. (b) If veteran, name war: _____ 3. (c) Social Security No. _____

4. Sex: Female 5. Color or race: white

6. (a) Single, widowed, married, divorced: Married

6. (b) Name of husband or wife: R.A. Ridgway 6. (c) Age of husband or wife if alive: _____ years

7. Birth date of deceased: 11 30 1884
(Month) (Day) (Year)

8. AGE: Years: 58 Months: 11 Days: 4 If less than one day: _____ hr. _____ min.

9. Birthplace: Randolph Co. Mo
(City, town, or county) (State or foreign country)

10. Usual occupation: Housewife

11. Industry or business: _____

MOTHER FATHER

12. Name: J. A. W. Heckerman

13. Birthplace: Randolph Co Mo
(City, town, or county) (State or foreign country)

14. Maiden name: Josephine Roberts

15. Birthplace: Randolph Co Mo
(City, town, or county) (State or foreign country)

16. (a) Informant: P. A. Ridgway

(b) Address: Jacksonville, Mo. RR

17. (a) Burial (b) Date thereof: 11 6 1943
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation: Liberty Cem.

18. (a) Signature of funeral director: Robert S. Keener

(b) Address: Macon Mo

19. (a) _____ (b) _____
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month: November day: 4
year: 1943 hour: _____ minute: _____ M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____; that I last saw him _____ alive on _____, 19____; and that death occurred on the date and hour stated above.

Immediate cause of death: Cerebral Hemorrhage instant from Skull fracture

Due to: _____

Due to: _____

Other conditions: _____ (Include pregnancy within 3 months of death)

Major findings: _____ Of operations: _____

Of autopsy: _____

160
39

Duration

PHYSICIAN

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): Accident

(b) Date of occurrence: November 4, 1943

(c) Where did injury occur?: Jacksonville, Randolph Co. Mo.
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?
Fell into cellar at home
(Specify type of place) (e) Means of injury: _____

23. Signature: C. R. Stuyvesant (M. D. or other) _____
Address: Jacksonville Mo Date signed: Dec 15/43

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

1036

0383 6 1 1981

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..... *Robert Skinner*

Licensed Embalmer No. *75-1*

P. O. Address *Macon Mo*

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.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. Jan
Registrar's No. _____

Registration District No. 295 Primary Registration District No. 60087

1. PLACE OF DEATH:
(a) County Randolph
(b) City or town Rural Salt River Twp
(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether
In this community _____ years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State _____ (b) County _____
(c) City or town _____ (If outside city or town limits, write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Mina Ridgway
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month Jan Day 19 Year 1944
21. I hereby certify that I attended the deceased from _____, 19____;
that I last saw him/her alive on _____, 19____;
and that death occurred on the date and hour stated above.
Immediate cause of death _____

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced m
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ Year _____
7. Birth date of deceased Nov. 30
(Month) (Day) (Year)

8. AGE: Years 68 Months 11 Days _____ If less than one day _____ min.

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

10. Usual occupation _____

11. Industry or business _____

MOTHER, FATHER {
12. Name _____
13. Birthplace _____ (City, town, or county) (State or foreign country)
14. Maiden name _____ (State or foreign country)
15. Birthplace _____ (City, town, or county) (State or foreign country)

16. (a) Informant _____
(b) Address _____

17. (a) _____ (b) Date thereof _____ (Month) (Day) (Year)
(Burial, cremation, or removal)
(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____
(b) Address _____

19. (a) (2-2-44) (b) Erna Nave
(Date received local registrar) (Registrar's signature)

Due to _____
Due to _____
Other conditions (include pregnancy within 3 months of death) _____
Major findings: Of operations _____
Of autopsy _____

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) _____
(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?
While at work? _____ (Specify type of place) (e) Means of injury _____
23. Signature _____ (M. D. or other) _____
Address _____ Date signed _____

SUPPLEMENTARY

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

Duration
PHYSICIAN
Underline the cause to which death should be charged statistically.

5-43494