

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-024381

FILED VS JUL 27 1959

Registration District No. 30 Primary Registration District No. 5179 Registrar's No. 32

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <i>Camden</i>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Ohio</i> b. COUNTY <i>Madison</i>			
b. CITY (If outside corporate limits give TOWNSHIP only) OR TOWN <i>Osage Park T</i>		Length of stay in 1b <i>3 days</i>	c. CITY OR TOWN <i>Cincinnati</i>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <i>Sais Park Resort</i>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <i>6840 Taylor Road</i>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <i>Ernest Joseph Paine</i>			4. DATE OF DEATH Month Day Year <i>July 22 1959</i>			
5. SEX <i>Male</i>	6. COLOR OR RACE <i>whit</i>	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <i>July 6 - 1954</i>	9. AGE (last birthday) <i>7</i>	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Home + school</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>none</i>	11. BIRTH PLACE (City and state or country) <i>St Louis, Mo</i>	12. CITIZEN OF WHAT COUNTRY <i>U.S.A.</i>		
13. FATHER'S NAME <i>Norman M Paine</i>		13b. MOTHER'S MAIDEN NAME <i>Delila Delila Krapp Paine</i>		14. NAME OF HUSBAND OR WIFE <i>None</i>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <i>no</i>		16. SOCIAL SECURITY NO. <i>no</i>	17. INFORMANT Address <i>Norman M Paine Cincinnati Ohio</i>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Suffocation</i>					INTERVAL BETWEEN ONSET AND DEATH <i>Sudden</i>	
DUE TO (b) <i>accidental Drowning</i>						
DUE TO (c) _____						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <i>While alone in water too deep to wade + could not swim</i>					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 type="checkbox"/> NO <input checked="" 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.) <i>Drowning at Lake Resort - drowned at the foot of a</i>				
20c. TIME OF INJURY Hour Month, Day, Year <i>7 p.m. July 22 - 59</i>	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.) <i>Sais Park Resort</i>	20f. CITY, TOWN, OR LOCATION <i>Lake of the Gaskes, Camden</i>	COUNTY <i>Mo</i>	STATE <i>Mo</i>	
21. I attended the deceased from <i>July 22 - 1959</i> and last saw her/him alive on <i>7 p.m.</i> on the date stated above, and to the best of my knowledge, from the causes stated. Death occurred at _____						
22a. SIGNATURE (Degree or title) <i>Abbie Woolery - County Coroner</i>			22b. ADDRESS <i>Camdenton, Mo</i>		22c. DATE SIGNED <i>July 23 - 59</i>	
23a. BURIAL OR CREMATION, REMOVAL (Specify) <i>removal</i>	23b. DATE <i>July 23 - 59</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Sunset Hill</i>		23d. LOCATION (City, town, or county) <i>St Louis</i>	(State) <i>Mo</i>	
24. FUNERAL DIRECTOR ADDRESS <i>Keith M Kays</i>		25. DATE RECD. BY LOCAL REG. <i>ELdon - Mo July 23 - 1959</i>	26. REGISTRAR'S SIGNATURE <i>Zilpha J. Traw</i>			

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

6925 51 307.

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 Keith M. Page

Licensed Embalmer No. 3998

P. O. Address Eldon 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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.