RI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

-60-039468
STATE FILE NUMBER

.ED VS OCT 18 1960

Registration District No. 316 Primary Registration District No. — Registrar's No. 398

1. PLACE OF DEATH
a. COUNTY: ST FRANCOIS
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: DOE RUN — Length of stay in 1b: 7 Yrs.
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION — Inside Limits: Yes ☐ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MISSOURI b. COUNTY: ST.FRANCOIS
c. CITY OR TOWN: DOE RUN — Inside Limits: Yes ☒ No ☐
d. STREET ADDRESS (If outside, give location): gen del — Reside on Farm: Yes ☐ No ☒

3. NAME OF DECEASED (Type or print): First: DELLA Middle: MAE Last: RIDINGS
4. DATE OF DEATH: Month: OCT. Day: 12 Year: 1960
5. SEX: FEMALE
6. COLOR OR RACE: WHITE
7. Married ☒ Never Married ☐ Widowed ☐ Divorced ☐
8. DATE OF BIRTH: 4/29/83
9. AGE (last birthday): 77
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): HOUSE WIFE
10b. KIND OF BUSINESS OR INDUSTRY: UWN HOME
11. BIRTHPLACE (City and state or country): ILL.
12. CITIZEN OF WHAT COUNTRY: U.S.A.
13a. FATHER'S NAME: ANDREW DOBYNS
13b. MOTHER'S MAIDEN NAME: UNKNOWN
14. NAME OF HUSBAND OR WIFE: JOSEPH H RIDINGS
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.:
17. INFORMANT: JOSEPH H RIDINGS Address: DOE RUN MO.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 15 m
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b): Hypertension & arteriosclerosis — unk
DUE TO (c):
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)
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 Oct 1, 1960, to Oct 12 1960 and last saw him alive on Oct 12, 1960
Death occurred at 11:50 P.M. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE: [signature] (Degree or title) DC
22b. ADDRESS: Farmington Mo
22c. DATE SIGNED: 10/18/60

22d. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
23b. DATE: 10/15/60
23c. NAME OF CEMETERY OR CREMATORY: ST.FRANCOIS MEM. PARK
23d. LOCATION (City, town, or county) (State): NEAR BONNE TERRE MO.
24. FUNERAL DIRECTOR ADDRESS: C.H.COZEAN FARMINGTON MO.
25. DATE RECD. BY LOCAL REG.: Oct. 15, 1960
26. REGISTRAR'S SIGNATURE: Esther Rudloff

(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT BY AFFIDAVIT OF

MAR 23 1961

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed b

or by _____, Student Embalmer No._____

working under my personal supervision.

Student_____ Signed_____

Signature of Student Embalmer

Licensed Embalmer No. 40

P. O. Address_____

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