SSOURI DIVISION OF HEALTH — STANDARD CERTIFICATE OF DEATH

TMENT OF PUBLIC HEALTH AND WELFARE

-61-037509
STATE FILE NUMBER

AMENDED

Registration District No. 169 Primary Registration District No. _____ Registrar's No. 32

FILED OCT 16 1961

1. PLACE OF DEATH
a. COUNTY: Knox
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: Edina — Length of stay in 1b
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION: Residence — Inside Limits: Yes [X] No [ ]

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Mo — b. COUNTY: Knox
c. CITY OR TOWN: Edina — Inside Limits: Yes [ ] No [ ]
d. STREET ADDRESS (If outside, give location) — Reside on Farm: Yes [ ] No [ ]

3. NAME OF DECEASED (Type or print): First BIRNEY — Middle EDWIN — Last RIDGE

4. DATE OF DEATH: Month Oct — Day 10, — Year 1961

5. SEX: M
6. COLOR OR RACE: W
7. Married [X] Never Married [ ] Widowed [ ] Divorced [ ]
8. DATE OF BIRTH: 17Dec1908
9. AGE (last birthday): 52 — 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): Welder
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (City and state or country): Brashear, Mo
12. CITIZEN OF WHAT COUNTRY: USA

13a. FATHER'S NAME: Milton L. Ridge
13b. MOTHER'S MAIDEN NAME: Effie I. Moore
14. NAME OF HUSBAND OR WIFE: Margaret Keaney

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) yes — (If yes, give war or dates of service) W W II
17. INFORMANT: Mrs. Margaret Keaney — Address: Edina, mo

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Epidermoid Carcinoma
DUE TO (b): of L. Pyriform Sinus C
DUE TO (c): Metastases.
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
INTERVAL BETWEEN ONSET AND DEATH: 2 years

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 [X]
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 [X] 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 23, 1959 to October 10, 1961 and last saw her/him alive on Oct 3, 1961
Death occurred at 10:00 A.M. m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title): Waldo B. Isom MD
22b. ADDRESS: Knox City, Missouri
22c. DATE SIGNED: 10/10/61

23a. BURIAL, CREMATION, REMOVAL (Specify): burial
23b. DATE: 12 Oct1961
23c. NAME OF CEMETERY OR CREMATORY: National Cemetery
23d. LOCATION (City, town, or county) (State): Quincy, Ill

24. FUNERAL DIRECTOR — ADDRESS: Hudson-Rimer Funeral Home, Edina, Mo
25. DATE RECD. BY LOCAL REG.: Oct-11-1961
26. REGISTRAR'S SIGNATURE: Nell S. Hunalt

(Licensed Embalmer's Statement on Reverse Side)

DATE AMENDED — INSTEAD OF — SHOULD READ — ITEM NO. — DOCUMENT — BY AFFIDAVIT OF — MEDICAL CERTIFICATION

OCT 19 1961

APR 12 1962

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~~ _____, Student Embalmer No._____

working under my personal supervision.

Student_____
Signature of Student Embalmer

Signed A B Rimer

Licensed Embalmer No. 5041

P. O. Address Edina, 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.