

FLORIDA STATE BOARD OF HEALTH  
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County Rural District No. \_\_\_\_\_  
 Precinct \_\_\_\_\_ Precinct No. \_\_\_\_\_ State File No. \_\_\_\_\_  
(Write name, not number)  
 or  
 Inc. Town \_\_\_\_\_ City or Town No. \_\_\_\_\_ Registered No. \_\_\_\_\_  
 or  
 City Jacobsville No. \_\_\_\_\_ St. \_\_\_\_\_ Ward \_\_\_\_\_  
(If death occurred in a hospital or institution, give its NAME instead of street and number)  
 Length of residence in city or town where death occurred 24 yrs. 0 mos. 0 ds. How long in U. S. if of foreign birth? 0 yrs. 0 mos. 0 ds.

2. FULL NAME Richard Remington

(a) Residence: No. 1213 Madison St. \_\_\_\_\_ Ward \_\_\_\_\_  
(Usual place of abode) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE Col 5. Single, married, widowed or divorced (write the word) Married  
 5a. If married, widowed or divorced HUSBAND of (or) WIFE of Arbuthnot Remington  
 6. DATE OF BIRTH (month, day and year) \_\_\_\_\_  
 7. AGE Years 27 Months \_\_\_\_\_ Days \_\_\_\_\_ If LESS than 1 day 0 hrs. or 0 min.  
 8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Housewife  
 9. Industry or business in which work was done, as silk mill, sawmill, bank, etc. \_\_\_\_\_  
 10. Date deceased last worked at this occupation (month and year) \_\_\_\_\_ 11. Total time (years) spent in this occupation \_\_\_\_\_

12. BIRTHPLACE (city or town) \_\_\_\_\_ (State or country) \_\_\_\_\_

13. NAME Richard Remington

14. BIRTHPLACE (city or town) \_\_\_\_\_ (State or country) \_\_\_\_\_

15. MAIDEN NAME Quacy

16. BIRTHPLACE (city or town) \_\_\_\_\_ (State or country) \_\_\_\_\_

17. INFORMANT Anna Williams (Address) 1222 Madison

18. BURIAL, CREMATION OR REMOVAL Place New Mt. Lebanon Cemetery #124 19 35

19. UNDERTAKER John J. Soper (Address) 421 W. 1st St.

20. FILED \_\_\_\_\_ 19 \_\_\_\_\_ Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (month, day, and year) April 24 19 35

22. I HEREBY CERTIFY, That I attended deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_

I last saw h. \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_, death is said to have occurred on the date stated above, at \_\_\_\_\_ m.

The principal cause of death and related causes of importance in order of onset were as follows:

Date of onset

Contributory causes of importance not related to principal cause:

Name of operation \_\_\_\_\_ Date of \_\_\_\_\_

What test confirmed diagnosis? \_\_\_\_\_ Was there an autopsy? \_\_\_\_\_

23. If death was due to external causes (violence) fill in also the following: Accident, suicide, or homicide? \_\_\_\_\_ Date of injury \_\_\_\_\_, 19\_\_\_\_

Where did injury occur? \_\_\_\_\_ (Specify city or town, county, and State)  
 Specify whether injury occurred in industry, in home, or in public place.

Manner of injury \_\_\_\_\_

Nature of injury \_\_\_\_\_

24. Was disease or injury in any way related to occupation of deceased? \_\_\_\_\_

If so, specify \_\_\_\_\_

(Signed) \_\_\_\_\_ M.D.

(Address) Rural County Hospital

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

