

CERTIFICATE OF DEATH

CLASS NO.

NO. OF RECORD

36264

CENSUS TRACT NO.

DISTRICT OF COLUMBIA HEALTH DEPARTMENT, BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH: (a) Street address Glenn Dale Sanitarium (b) Name of hospital or institution Glenn Dale, Maryland (c) Length of stay: In hospital or institution _____ (d) In District of Columbia _____

2. USUAL RESIDENCE OF DECEASED: (a) State Dist. Of Col. (b) County _____ (c) City or town Washington, D.C. (If outside city or town limits write RURAL) (d) Street address 3100 Monroe Street N.E. (If rural give location) (e) If foreign born, how long in U. S. A.? _____ years

3. (a) FULL NAME (Print) IDA D. RANKE

3. (b) SOCIAL SECURITY NO. None

3. (c) IF VETERAN, NAME WAR _____

4. SEX:	5. COLOR OR RACE	6. (a) SINGLE, MARRIED, WIDOWED, DIVORCED
Female	White	Widowed

6. (b) NAME OF HUSBAND OR WIFE Harry E. Ranke

7. BIRTH DATE OF DECEASED 1863
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If LESS than one day _____ hr. _____ min.
	79			

9. BIRTHPLACE Baltimore, Maryland
(City, town or county) (State or foreign country)

10. USUAL OCCUPATION Retired

11. INDUSTRY OR BUSINESS _____

12. NAME (Print) Charles Dinger

13. BIRTHPLACE Maryland
(City, town, or county) (State or foreign country)

14. MAIDEN NAME (Print) Amelia Weiss

15. BIRTHPLACE Maryland
(City, town, or county) (State or foreign country)

16. (a) INFORMANT Mrs. Ethel M. Pidgeon

(b) ADDRESS 3100 Monroe Street N.E.

(c) RELATION OF INFORMANT TO DECEDENT Daughter

17. (a) PLACE OF BURIAL, CREMATION, OR REMOVAL _____

Congressional Cemetery

(b) DATE April 25, 1942
(Month) (Day) (Year)

18. (a) Martin W. Hysong Company
(Signature of funeral director)

(b) ADDRESS 1300 N Street Northwest

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 21, 1942
(Month) (Day) (Year)
at 4:45 P. m.
(State exact time of death)

21. I HEREBY CERTIFY that I attended the deceased from _____, 19____, to _____, 19____;
That I last saw h_____ alive on _____, 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death	DURATION
<u>Pulmonary Tuberculosis</u>	
Due to _____	
Due to _____	
Other conditions _____	
PHYSICIAN _____	

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, in industrial place, in public place? _____
(Specify type of place)

(e) Means of injury _____

23. SIGNATURE Leo V. Schneider, registrar M.D.
Address Glenn Dale, Maryland Date signed April 22/42

IMPORTANT NOTICE.—Failure to submit a Certificate of Death to the Health Department within forty-eight hours after the date of death is a violation of the laws of the District of Columbia. It is also a violation for any person or persons having custody of a body to hold it unburied for a longer period than one week after death. Violation of these laws is punishable by fine or imprisonment or both.

THIS IS A PERMANENT RECORD. PLEASE FILL OUT WITH TYPEWRITER (EXCEPT SIGNATURES) OR WRITE PLAINLY WITH UNFADING INK. Every item of information should be carefully supplied. AGE should be stated EXACTLY; if unknown, give approximate age. PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. Space for ref. may be found on the other side.