

REG 18
Aug 88
MH3745

New Jersey State Department of Health
CERTIFICATE OF DEATH

STATE USE ONLY

0021663

1 NAME OF DECEASED (First) Helen			(Middle) M.		(Last) Cameron		
2 DATE OF DEATH 4/9/91		3 SEX F	4 DATE OF BIRTH 4/17/20		5a AGE - Last Birth- day 88	5b UNDER 1 YEAR Months _____ Days _____	5c UNDER 1 DAY Hours _____ Minutes _____
6 SOCIAL SEC. NO. 154-05-8463			7a PLACE OF DEATH HOSPITAL: <input type="checkbox"/> INPATIENT <input type="checkbox"/> ER/OUTPATIENT <input type="checkbox"/> DOA <input checked="" type="checkbox"/> OTHER: <input checked="" type="checkbox"/> NURSING HOME <input type="checkbox"/> RESIDENCE <input type="checkbox"/> OTHER (Specify)				
7b FACILITY NAME (If not institution, give street and no.) Burlington Woods Convalescent Center Burl. Twp.				7c CITY/TOWN OR LOCATION Burlington		7d COUNTY Burlington	
8a RESIDENCE (State) NJ	8b COUNTY Burlington		8c CITY OR TOWN Florence		8d STREET AND NUMBER 423 W. 3rd St.		8e INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO
8f ZIP CODE 08518		9 BIRTHPLACE (City & State, or Foreign Country) Jacobstown, NJ			10a DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		10b IF YES, WAR DATES (From, To) -
11 MARITAL STATUS <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> MARRIED <input type="checkbox"/> DIVORCED			12 SURVIVING SPOUSE (If wife, Maiden Name) None		13 USUAL OCCUPATION (Kind of work done most of life, even if retired) Housewife		14 KIND OF BUSINESS OR INDUSTRY Home
15 NAME AND ADDRESS OF LAST EMPLOYER None							
16 RACE 1 <input checked="" type="checkbox"/> WHITE 2 <input type="checkbox"/> BLACK		3 <input type="checkbox"/> AMER. INDIAN 4 <input type="checkbox"/> OTHER (Specify):		17 OF HISPANIC ORIGIN? IF YES, SPECIFY <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		18 DECEDENT'S EDUCATION Highest Grade Completed -	
19 NAME OF FATHER (First) (Middle) (Last) Harry _____ Davis		20 MAIDEN NAME OF MOTHER (First) (Middle) (Last) Mary _____ Pullen		21a NAME OF INFORMANT Loretta Weeast		21b RELATIONSHIP Daughter	
22a DISPOSITION <input checked="" type="checkbox"/> BURIAL <input type="checkbox"/> CREMATION <input type="checkbox"/> ENTOMBMENT <input type="checkbox"/> OTHER (Specify):		22b NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery				22c CITY OR TOWN Florence	
22d STATE NJ		23a NAME AND ADDRESS OF FUNERAL HOME Dennison Funeral Home - 214 W. Front St, Florence, NJ 08518					
23b SIGNATURE OF FUNERAL DIRECTOR <i>Richard S. Dennison</i>			23c N.J. LICENSE NO. 2796		24a SIGNATURE OF LOCAL REGISTRAR <i>Patricia Baker</i>		24b DATE RECEIVED 4-10-91
25a TIME OF DEATH 7:00 A M		25b DATE AND HOUR PRONOUNCED DEAD DATE: 4-9-91		HOUR: 8:05 A M		25c TO THE BEST OF MY KNOWLEDGE, DEATH OCCURRED AT TIME, DATE AND PLACE INDICATED	
25d DATE SIGNED 4-9-91		25e SIGNATURE OF PRONOUNCER (If different than certifier) <i>BP</i>					

26. PART I IMMEDIATE CAUSE (Enter the diseases, injuries or complications that caused the death. Do not enter the mode of dying, such as cardiac or INTERVAL BETWEEN ON-

Items 1 and 7 to be typed by Funeral Director

To be printed by Physician

DATE OF DEATH: 4-9-91 TIME OF DEATH: 7:00 AM

PHYSICIAN: Benny Riviere Jr. D.O.

NAME OF DECEASED AS KNOWN BY ATTENDING PHYSICIAN

STATE USE ONLY

IND/OCC
961914

CAUSE
414.0

PLACE OF ACC

CROSS CLASS

29 DEATH DUE TO <input checked="" type="checkbox"/> NATURAL <input type="checkbox"/> ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE		<input type="checkbox"/> PENDING INVESTIGATION <input type="checkbox"/> COULD NOT BE DETERMINED		30a DATE OF INJURY		30b TIME OF INJURY M		30c INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO		30d DESCRIBE HOW INJURY OCCURRED	
30f LOCATION OF INJURY (Number and Street)		30g CITY AND COUNTY		30h STATE		30i PLACE <input type="checkbox"/> STREET <input type="checkbox"/> HOME <input type="checkbox"/> FARM <input type="checkbox"/> OFFICE BUILDING <input type="checkbox"/> FACTORY <input type="checkbox"/> OTHER (Specify):					
31a NAME AND ADDRESS OF CERTIFIER B. Riviere Jr. D.O. 216 South Hill St. Florence, NJ						31b TO THE BEST OF MY KNOWLEDGE, DEATH OCCURRED DUE TO CAUSES LISTED ABOVE		31c CERTIFYING PHYSICIAN <input type="checkbox"/> MEDICAL EXAMINER <input checked="" type="checkbox"/> PRONOUNCER AND CERTIFIER		31d DATE SIGNED 4-9-91	
SIGNATURE OF CERTIFIER <i>BP</i>											