STATE OF ILLINOIS — ORIGINAL

State Board of Health - Bureau of Vital Statistics

CERTIFICATE OF BIRTH

577 — Registered No. 32

1. PLACE OF BIRTH

County of Cook

Township or Road District } or Incorp. Town or Village of } or City of Evanston

Registration Dist. No. 3107

Primary Dist No. 3107

Hospital or Institution (Name) Evanston Hospital — Ward

2. FULL NAME OF CHILD Marguerite Lloyd Rick — {If child is not yet named, make supplemental report as directed.

3. Sex of Child	4. Twin, triplet, or other? (To be answered only in event of plural births)	Number in order of birth	5. Date of birth
Female			Jan. (Month) 17 (Day) 1935 (Year)

FATHER

6. FULL NAME: John Kellogg Rick

7. RESIDENCE: 192 Glenwood Ave. Hubbard Wd. Ill.

8. COLOR: White — 9. AGE AT LAST BIRTHDAY: 30 Years

10. BIRTHPLACE (State or Country): Illinois

11. OCCUPATION: Salesman

MOTHER

12. FULL MAIDEN NAME: Marguerite Lloyd.

13. RESIDENCE: 192 Glenwood Ave. Hubbard Wd. Ill

14. COLOR: White — 15. AGE AT LAST BIRTHDAY: 24 Years

16. BIRTHPLACE (State or Country): Baltimore.

17. OCCUPATION: Housewife.

18. Number of children born to this mother, including present birth: Three

19. Number of children of this mother now living: Three

20. CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was born alive at 8:16 A. M., on the date above stated.

* When there was no attending physician or midwife, then the father, mother, householder, etc., shall make this return.

21. (Signature) Charles E. Galloway M. D. Midwife (Physician or Midwife)

Address Evanston Ill. Telephone 6111

22. Given name added from a supplemental report....., 19.....

.....
Registrar

23. Filed 2/1/20, 19..... Dr. C. T. ROOME Registrar

N. B.—In case of more than one child at a birth, a SEPARATE RETURN must be made for each, and the number of each, in order of birth, stated.

WRITE PLAINLY, WITH UNFADING INK - - THIS IS A PERMANENT RECORD

I HEREBY CERTIFY THAT the foregoing is a true and correct copy of the record as made from the original certificate for the person named therein and that this certificate was established and filed with the Department of Public Health in accordance with the statutes of Illinois.

STATE REGISTRAR—VITAL RECORDS

by Robert Templeton

DEPUTY STATE REGISTRAR

SPRINGFIELD

AUGUST 14, 1984

THIS IS NOT A VALID CERTIFIED COPY WITHOUT THE EMBOSSED SEAL AND SIGNATURE OF THE STATE REGISTRAR

STATE OF NEW JERSEY

B0000688798

REG-18
AUG 03

NEW JERSEY DEPARTMENT OF HEALTH AND SENIOR SERVICES
CERTIFICATE OF DEATH

STATE FILE NUMBER

TO BE COMPLETED BY FUNERAL DIRECTOR

Time of Death: 5:25 ☐AM ☒PM
Date of Death: 12/19/04
Name of Decedent as Known by Physician: AYERS, Marguerite

1a. Legal Name of Decedent (First, Middle, Last): Marguerite Ayers
1b. Also Known As (AKA), If Any (First, Middle, Last):
2. Sex: F
3. Social Security Number: 722-12-8844
4a. Age-Last Birthday: 79 Years
4b. Under 1 Year: Months / Days
4c. Under 1 Day: Hours / Minutes
5. Date of Birth (Mo/Dy/Yr): 1-17-25
6. Birthplace (City & State/Foreign Country): Winnetka, IL
7a. Residence-State: NJ
7b. County: Morris
7c. Municipality/City: Mendham Twp.
7d. Street and Number: 6 Schoolhouse Lane
7e. Apt. No.:
7f. Zip Code: 07926
7g. Inside City Limits? ☒Yes ☐No
8a. Ever in US Armed Forces? ☐Yes ☒No ☐Unk
b. If yes, Name of War: N/A
c. War Service Dates (From/To):
9. Marital Status at Time of Death: ☐Never Married ☒Married ☐Married but Separated ☐Divorced ☐Widowed ☐Unknown
10. Surviving Spouse Name (If wife, name prior to first marriage): C. Freeman Ayers
11. Father's Name (First, Middle, Last): John K. Rich
12. Mother's Name Prior to First Marriage (First, Middle, Last): Marguerite Theobald Lloyd
13a. Name of Informant: Charles Wiemers
13b. Relationship to Decedent: son
13c. Mailing Address (Street and Number, City, State, Zip Code): 11008 Glueck Ln. Kensington, MD, 20895
14. Method of Disposition: ☐Burial ☒Cremation ☐Removal from State ☐Other (Specify): ☐Donation ☐Entombment
15. Place of Disposition (Name of cemetery, crematory, other place): Somerset Hills Crematory
16. Location-City, Town and State: Basking Ridge, NJ
17. Name and Complete Address of Funeral Facility: Bailey Funeral Home, 8 Hilltop Rd., Mendham, NJ, 07945
18. Signature of Funeral Director: Thomas Day
19. NJ License Number: 4037
20. Decedent Education (Highest degree or level of school completed at time of death.): ☐Grade 8 or less ☐Grade 9-12; no diploma ☐High school graduate or GED ☒Some college credit, no degree ☐Associate degree (AA, AS) ☐Bachelor's degree (BA, AB, BS) ☐Master's degree (MA, MS, MEd, MSW) ☐Doctorate (PhD, EdD) or Professional degree (MD, DDS, JD)
21. Decedent of Hispanic Origin? (Check one or more boxes that best describe if decedent is Spanish/Hispanic/Latino. Check "No" box if decedent is not Spanish/Hispanic/Latino.): ☒No, Not Spanish/Hispanic/Latino ☐Yes, Mexican, Mexican American, Chicano ☐Yes, Puerto Rican ☐Yes, Cuban ☐Yes, Other Spanish/Hispanic/Latino (Specify):
22. Decedent Race - Check one or more boxes to indicate what race the decedent considered himself/herself to be.: ☒White ☐Black or African American ☐American Indian or Alaska Native (Enrolled or principal tribe): ☐Asian Indian ☐Filipino ☐Korean ☐Chinese ☐Japanese ☐Vietnamese ☐Other Asian (Specify): ☐Native Hawaiian ☐Guamanian or Chamorro ☐Samoan ☐Other Pacific Islander (Specify): ☐Other (Specify):
23. Occupation of Decedent (Type of work done most of life, even if retired): Homemaker
24. Kind of Business/Industry: N/A
25. Name and Address of Last Employer: N/A

TO BE COMPLETED BY MEDICAL CERTIFIER

FOR STATE USE ONLY
Place of Accident
Cross Class
Received for Limb Only ☐
Record Contains Amendment ☐

ITEMS 26-30 MUST BE COMPLETED BY PERSON WHO PRONOUNCES OR CERTIFIES DEATH
26. Date Pronounced Dead (Mo/Day/Yr): 12/19/04
27. Time Pronounced Dead: 6:45 ☐AM ☒PM
28. Signature of Person Pronouncing Death (If other than Certifier):
29. License Number: 26NO-00621420
30. Date Signed (Mo/Day/Yr): 12/19/04
31. Date of Death (Mo/Day/Yr): 12/19/04
32. Time of Death: 5:25 ☐AM ☒PM
33. Was Medical Examiner Contacted? ☐Yes ☒No
34. PLACE OF DEATH (Check only one)
If Death Occurred in a Hospital: ☐Inpatient ☐Dead on Arrival ☐Emergency Room or Outpatient
If Death Occurred Somewhere Other Than a Hospital: ☐Hospice Facility ☐Nursing Home/Long Term Care Facility ☒Decedent's Home ☐Other (Specify):
35a. Facility Name (If not institution, give street and number): 6 Schoolhouse Lane
35b. Municipality: Mendham Twp.
35c. County: Morris

CAUSE OF DEATH
36a. PART I - IMMEDIATE CAUSE - final disease or condition resulting in death. Subsequently list conditions, if any, leading to the cause listed on Line a. Enter the UNDERLYING CAUSE (disease or injury that initiated the events resulting in death) LAST.
Immediate Cause - (Enter chain of events (diseases, injuries, or complications) that directly caused death. DO NOT enter terminal events such as cardiac arrest, or ventricular fibrillation without showing etiology. DO NOT ABBREVIATE. Enter only one cause per line. Add additional lines if necessary.)
a. IDIOPATHIC PULMONARY FIBROSIS — Interval Between Onset and Death: YEARS
Due to (or as a consequence of):
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.
36b. PART II - Enter other significant conditions contributing to death but not resulting in underlying cause given in PART I.
37. Was an Autopsy Performed? ☐Yes ☒No
38. Were Autopsy Findings Available to Complete Cause of Death? ☐Yes ☐No
39. Date of Injury (Mo/Day/Yr):
40. Time of Injury: ☐AM ☐PM
41. Place of Injury (e.g., home, construction site, restaurant):
42. Injury at Work? ☐Yes ☐No
43a. Location of Injury (Number and Street, Zip Code):
43b. Municipality:
43c. County:
43d. State:
44. Describe How Injury Occurred:
45. If Transportation Injury: ☐Driver/Operator ☐Passenger ☐Pedestrian ☐Other (specify):
46. Manner of Death: ☒Natural ☐Accident ☐Suicide ☐Homicide ☐Pending Investigation ☐Could not be determined
47. Did Decedent Have Diabetes? ☐Yes ☒No ☐Unknown
48. Did Tobacco Use Contribute to Death? ☐Yes ☐Probably ☒No ☐Unknown
49. If Female: ☐Not pregnant within past year ☐Pregnant at time of death ☐Not pregnant, but pregnant within 42 days of death ☐Not pregnant, but pregnant 43 days to 1 year before death ☐Unknown if pregnant within the past year
50. Certifier (Check only one): ☒Certifying physician-To the best of my knowledge, death occurred due to the cause(s) and manner stated. ☐Pronouncing and Certifying Physician-To the best of my knowledge, death occurred at the time, date, and place, and due to the cause(s) and manner stated. ☐Medical Examiner-On the basis of examination/investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
51. Name, Address and Zip Code of Certifier: ROBERT CAIONE 8 SAMPLE ROAD CEDAR KNOLL NJ 07927
52. Signature of Certifier:
53. License Number: NJ24110
54. Date Certified (Mo/Day/Yr): 12/20/04
55. Signature of Local Registrar: Maureen Massey, Registrar
56. District No.: 1418
57. Date Received: 12/22/04
Local File Number:

H5119

Date: December 22, 2004
Issued By:
Mendham Borough
Health Department