

FILED MAY 20 1957

STANDARD CERTIFICATE OF DEATH

STATE FILE NUMBER 16762

Registration District No. 128 Primary Registration District No. 2000 Registrar's No. 456

300  
1-56

All symptoms will be listed. All diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

1. PLACE OF DEATH a. COUNTY <b>Greene</b>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Transient</b> b. COUNTY		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Springfield</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>Transient</b>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF HOSPITAL OR INSTITUTION <b>Medical Center for Federal Prisoners</b>		Length of stay in lb <b>11yrs1mollidas</b>	d. STREET ADDRESS (If outside, give location) <b>Transient</b>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>Vincent</b> Middle Last <b>Palokis</b>			4. DATE OF DEATH Month <b>May</b> Day <b>12th</b> Year <b>1957</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>December 19, 1897</b>		9. AGE (In years last birthday) <b>59</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Varied</b>	11. BIRTHPLACE (City and state or country) <b>Lithuania</b>		12. CITIZEN OF WHAT COUNTRY? <b>Lithuania</b>
13. FATHER'S NAME <b>Unknown</b>			14. MOTHER'S MAIDEN NAME <b>Elizabeth Miller</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	17. INFORMANT <b>FILE: MCFF Springfield, Missouri</b>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pulmonary edema.</b>					INTERVAL BETWEEN ONSET AND DEATH <b>4 hours</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.					DUE TO (b) <b>Cardiac insufficiency.</b>
DUE TO (c) <b>Arteriosclerotic heart disease.</b>					<b>4 days</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
<b>Schizophrenic reaction, paranoid type.</b>					<b>4200</b>
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) *****		
20c. TIME OF INJURY Hour <b>*****</b> a. m. <b>*****</b> Month, Day, Year <b>*****</b>			*****		
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		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 <b>The Medical Staff</b> <b>3-26-53</b> to <b>5-12-57</b> and last saw <b>him</b> alive on <b>5-12-57</b>			Death occurred at <b>8:10</b> p. m. on the date stated above; and to the best of my knowledge, from the causes stated.		
22a. SIGNATURE <b>Clarence Koolker, M.D.</b>		22b. ADDRESS <b>Medical Center for Federal Prisoners, Springfield</b>		22c. DATE SIGNED <b>5-11-57</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>5-16-57</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Hazewood Cemetery</b>	23d. LOCATION (City, town, or county) (State) <b>Springfield, Mo</b>		
24. FUNERAL DIRECTOR <b>HYRE-GOODWIN, Inc.</b> ADDRESS <b>Springfield</b>		25. DATE RECD. BY LOCAL REG. <b>5-16-57</b>	26. REGISTRAR'S SIGNATURE <b>Walter Williamson</b>		

(Licensed Embalmer's Statement on Reverse Side)

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 *Lester T. Swadley* .....

Licensed Embalmer No. *481*

P. O. Address *Spring*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (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.