

FEDERAL BUREAU OF INVESTIGATION

FURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS SEP 29 1959

2 8535 59-033582
STATE FILE NUMBER

Registration District No. _____ Primary Registration District No. _____ Registrar's No. _____

RECEIVED

1. PLACE OF DEATH a. COUNTY _____ b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis Length of stay in 1b 52 days c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Louis Children's Hospital Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Ill. b. COUNTY Jackson c. CITY OR TOWN Grand Tower Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/> d. STREET ADDRESS _____ (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Donald Gene Bishop			4. DATE OF DEATH Month Day Year 9 15 1959				
5. SEX M	6. COLOR OR RACE W	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 7-24-59	9. AGE (last birthday) IF UNDER 1 YEAR: Months 1 Days 22 IF UNDER 24 HR: Hours _____ Min. _____			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		10b. KIND OF BUSINESS OR INDUSTRY none		11. BIRTHPLACE (City and state or country) Cape Girardeau, Mo.			
12. CITIZEN OF WHAT COUNTRY US		13a. FATHER'S NAME Donald Eugene Bishop		13b. MOTHER'S MAIDEN NAME Carolyn Grammer			
14. NAME OF HUSBAND OR WIFE none		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no					
16. SOCIAL SECURITY NO. none		17. INFORMANT Address Mary Ritter 500 So. Kingshighway					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory Arrest DUE TO (b) Arnold-Chiari Malformation DUE TO (c) Hydrocephalus Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.				INTERVAL BETWEEN ONSET AND DEATH 15 minutes 6 weeks 6 weeks			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)			PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown				
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	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 _____ s.m. _____ p.m. Month, Day, Year _____		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 7-25-59 to 9-15-59 and last saw him alive on 9-15-59 Death occurred at 8:50 A on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) Leonard Peter Rome M.D. <i>Leonard Peter Rome M.D.</i>			22b. ADDRESS 500 So. Kingshighway				
22c. DATE SIGNED 9-15-59			23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				
23b. DATE 9/17/59		23c. NAME OF CEMETERY OR CREMATORY Walker Hill Cemetery		23d. LOCATION (City, town, or county) (State) Grand Tower, Ill.			
24. FUNERAL DIRECTOR ADDRESS Crawshaw Funeral Home, Murphysboro, Ill		25. DATE RECD. BY LOCAL REG. SEP 16 '59		26. REGISTRAR'S SIGNATURE <i>Carl Smith, M.D.</i> MOB			

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

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 _____
Joseph J. Keady

Licensed Embalmer No. 7541

P. O. Address St. Louis, Mo.

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