

# FEDERAL BUREAU OF INVESTIGATION - STANDARD CERTIFICATE OF DEATH

FILED VS SEP 21 1959

59-033731

STATE FILE NUMBER

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_ Registrar's No. **2 8277**

INDEXED

<b>1. PLACE OF DEATH</b> a. COUNTY _____				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> COUNTY _____									
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Louis, Missouri</b>		Length of stay in 1b _____		c. CITY OR TOWN <b>Eminence</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>							
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Barnes Hospital</b>			Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <b>Gneral Del.</b>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>						
<b>3. NAME OF DECEASED</b> (Type or print) First <b>MAUDE</b> Middle <b>E.</b> Last <b>DEATHERAGE</b>				<b>4. DATE OF DEATH</b> Month <b>SEPT.</b> Day <b>5</b> Year <b>1959</b>									
<b>5. SEX</b> <b>Female</b>		<b>6. COLOR OR RACE</b> <b>White</b>		<b>7. Married</b> <input checked="" type="checkbox"/> <b>Never Married</b> <input type="checkbox"/> <b>Widowed</b> <input type="checkbox"/> <b>Divorced</b> <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <b>3-13-93</b>		<b>9. AGE (last birthday)</b> <b>66</b>		IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 24 HR Hours _____ Min. _____	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>At Home</b>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>Housewife</b>		<b>11. BIRTHPLACE</b> (City and state or country) <b>Salem, Missouri</b>		<b>12. CITIZEN OF WHAT COUNTRY</b> <b>USA</b>					
<b>13a. FATHER'S NAME</b> <b>Daniel Ramsey</b>				<b>13b. MOTHER'S MAIDEN NAME</b> <b>Iola Keithley</b>				<b>14. NAME OF HUSBAND OR WIFE</b> <b>Nep C. Deatherage</b>					
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>				<b>16. SOCIAL SECURITY NO.</b> <b>None</b>		<b>17. INFORMANT</b> Address <b>Nep Deatherage Eminence, Mo.</b>							
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CEREBRAL THROMBOSIS</b> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <b>CEREBRAL ARTERIOSCLEROSIS</b> DUE TO (c) _____ 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 checked="" type="checkbox"/> No <input type="checkbox"/> Unknown										INTERVAL BETWEEN ONSET AND DEATH <b>20 HOURS</b>  <b>5 YEARS</b>			
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		<b>20a. ACCIDENT</b> <input type="checkbox"/> <b>SUICIDE</b> <input type="checkbox"/> <b>HOMICIDE</b> <input type="checkbox"/>		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in PART I or PART II of item 18.) _____									
<b>20c. TIME OF INJURY</b> Hour _____ a.m. _____ p.m.		Month, Day, Year _____											
<b>20d. INJURY OCCURRED WHILE AT WORK</b> <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			<b>20e. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.) _____			<b>20f. CITY, TOWN, OR LOCATION</b> _____		COUNTY _____		STATE _____			
<b>21. I attended the deceased from</b> <b>8/28/59</b> <b>to</b> <b>9/5/59</b> <b>and last saw her</b> <input checked="" type="checkbox"/> <b>alive on</b> <b>9/5/59</b> Death occurred at <b>6:50 P.M.</b> <b>on</b> the date stated above, and to the best of my knowledge, from the causes stated.													
<b>22a. SIGNATURE</b> (Degree or title) <b>F. R. Bradley</b>					<b>22b. ADDRESS</b> <b>M. D. BARNES HOSPITAL</b>					<b>22c. DATE SIGNED</b> <b>9/6/59</b>			
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <b>Removal</b>			<b>23b. DATE</b> <b>9-8-59</b>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>New Eminence Cem.</b>			<b>23d. LOCATION</b> (City, town, or county) (State) <b>Eminence, Mo.</b>					
<b>24. FUNERAL DIRECTOR</b> ADDRESS <b>White-Mullen 118 N. Florissant Rd.</b>					<b>25. DATE RECD. BY LOCAL REG.</b> <b>SEP 8 '59</b>		<b>26. REGISTRAR'S SIGNATURE</b> <b>Loal Smith, M.D.</b> <i>S.P.</i>						

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 my self \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed Reinhold K. Lohmann

Licensed Embalmer No. 3395

P. O. Address St. Louis 35

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.