

FEDERAL BUREAU OF INVESTIGATION - STANDARD CERTIFICATE OF DEATH

RECEIVED SEP 22 1959

2 8000 59-033858
STATE FILE NUMBER

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

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		Length of stay in 1b 1/2 Hour	c. CITY OR TOWN Lemay (Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Anthony Hospital		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 517 Jeffords ave. Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Kelly Middle Sue Last Haeusser	4. DATE OF DEATH Month August Day 27 Year 1959
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5. SEX Female	6. COLOR OR RACE White	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 6-23-1959	9. AGE (last birthday) IF UNDER 1 YEAR: Months 2 Days 4 Hours _____ Min. _____ IF UNDER 24 HR: _____
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NI	10b. KIND OF BUSINESS OR INDUSTRY _____	11. BIRTHPLACE (City and state or country) St. Louis, Mo.	12. CITIZEN OF WHAT COUNTRY U S A
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13a. FATHER'S NAME George Haeusser	13b. MOTHER'S MAIDEN NAME Daryl Norris	14. NAME OF HUSBAND OR WIFE _____
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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 George Haeusser 517 Jeffords ave. Address _____
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Suffocation due to pituitary gland pressing upon the brain		INTERVAL BETWEEN ONSET AND DEATH _____
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (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 type="checkbox"/> No <input type="checkbox"/> Unknown
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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.)
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20c. TIME OF INJURY _____ Hour _____ a.m. _____ p.m.	Month, Day, Year _____
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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 _____
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21. I attended the deceased from _____ to _____ and last saw her/him alive on _____
Death occurred at **12 NOON** m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE Robert M. Quinn Deputy Coroner (Degree of 80%)	22b. ADDRESS 1300 Oak	22c. DATE SIGNED 8/28/59
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23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE Aug. 29, 1959	23c. NAME OF CEMETERY OR CREMATORY St. Trinity Cemetery	23d. LOCATION (City, town, or county) (State) 2000 Lemay Ferry Rd. Lemay, Mo.
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24. FUNERAL DIRECTOR C. Hoffmeister Mortuaries ADDRESS 7814 S. Broadway	25. DATE RECD. BY LOCAL REG. AUG 28 '59	26. REGISTRAR'S SIGNATURE Loard Smith. M.D.
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DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

5.0

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 John H. Hennes
Licensed Embalmer No. 4194
P. O. Address St. Louis

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.