

FEDERAL BUREAU OF INVESTIGATION U.S. DEPARTMENT OF JUSTICE

FILED VS SEP 22 1959

59-034094

STATE FILE NUMBER

2 8428

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

1. PLACE OF DEATH a. COUNTY _____ b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN ST. LOUIS, MO. Length of stay in 1b _____ c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION ST. LOUIS CITY HOSP. #1 Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY _____ c. CITY OR TOWN St. Louis Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> d. STREET ADDRESS (If outside, give location) 6649 Marmaduke Street., Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First Middle Last CLAUDE ARVEL MIDYETT				4. DATE OF DEATH Month Day Year SEPT. 11, 1959				
5. SEX Male	6. COLOR OR RACE White	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 2/16/1892	9. AGE (last birthday) 67	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HR Hours _____ Min. _____		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Grocer		10b. KIND OF BUSINESS OR INDUSTRY Grocery		11. BIRTHPLACE (City and state or country) Crawford County, Mo.		12. CITIZEN OF WHAT COUNTRY U.S.A		
13a. FATHER'S NAME Grant Midyett			13b. MOTHER'S MAIDEN NAME Laura Cottrell			14. NAME OF HUSBAND OR WIFE Florence Midyett		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No Nil			16. SOCIAL SECURITY NO. 498-20-0619			17. INFORMANT Address Florence Midyett, 6649 Marmaduke Street.,		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Basilar artery thrombolis</u> 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 checked="" type="checkbox"/> No <input type="checkbox"/> Unknown INTERVAL BETWEEN ONSET AND DEATH 7 wks.								
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" 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 a.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 <u>8/2/59</u> to <u>9/11/59</u> and last saw her/him alive on <u>9/11/59</u> Death occurred at <u>8:30 A.M.</u> on the date stated above, and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE (Degree or title) <u>Robert C. Kane M.D.</u>				22b. ADDRESS 1515 LAFAYETTE AVE.			22c. DATE SIGNED 9/11/59	
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE 9-11-1959		23c. NAME OF CEMETERY OR CREMATORY Boss Cemetery		23d. LOCATION (City, town, or county) (State) Boss, Missouri.		
24. FUNERAL DIRECTOR ADDRESS Albert H. Hoppe, Inc., 4700 Washington				25. DATE RECD. BY LOCAL REG. SEP 1 1959		26. REGISTRAR'S SIGNATURE <u>Robert Smith, M.D.</u>		

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 *John J. Strauss*
Licensed Embalmer No. 4408
P. O. Address *Strauss*

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.

notarized _____