

FEDERAL BUREAU OF INVESTIGATION - STANDARD CERTIFICATE OF DEATH
FILED VS SEP 29 1959 **2 8412** **59-034169**
 Registration District No. _____ Primary Registration District No. _____ Registrar's No. _____ STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MISSOURI b. COUNTY DENT	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN 915 N GRAND ST LOUIS MO		Length of stay in 1b 16 DAYS	c. CITY OR TOWN SALEM
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION VETS ADMIN HOSPITAL		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (if outside, give location) 401 W SIXTH
		Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First ROBERT Middle O. Last PARKER			4. DATE OF DEATH Month SEPTEMBER Day 10 Year 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 9/27/17	9. AGE (last birthday) 42	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CARPENTER'S HELPER		10b. KIND OF BUSINESS OR INDUSTRY CARPENTRY	11. BIRTHPLACE (City and state or country) SALEM, MISSOURI		12. CITIZEN OF WHAT COUNTRY USA	
13a. FATHER'S NAME UNKNOWN		13b. MOTHER'S MAIDEN NAME BESSIE PARKER		14. NAME OF HUSBAND OR WIFE RUTH E PARKER		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) YES WW II		16. SOCIAL SECURITY NO. 495-16-5522	17. INFORMANT Address VA HOSP RECORDS 915 N GRAND ST LOUIS MO.			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) SHOCK		2 DAYS
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) GENERALIZED INFECTION		2 WEEKS
DUE TO (c) HODGKINS DISEASE 201x		6 YEARS
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.) NONE
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 SALEM, MISSOURI
21. I attended the deceased from 8/25/59 to 9/10/59 and last saw him alive on 9/10/59 Death occurred at 7:50 PM on the date stated above, and to the best of my knowledge, from the causes stated.		

22a. SIGNATURE (Degree or title) Harry A. Feagard M.D.		22b. ADDRESS VAH, ST LOUIS, MISSOURI	22c. DATE SIGNED 9/11/59
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 9/13/59	23c. NAME OF CEMETERY OR CREMATORY Local	23d. LOCATION (City, town, or county) (State) Salem, Missouri.
24. FUNERAL DIRECTOR ADDRESS Albert H. Hoppe, 4700 Washington Blvd.,		25. DATE RECD. BY LOCAL REG. SEP 11 59	26. REGISTRAR'S SIGNATURE Carl Smith M.D.

DOCUMENT
 MEDICAL CERTIFICATION
 BY AFFIDAVIT OF

SEP 8 1959

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 Stanley H. Hixson

Licensed Embalmer No. 4193

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.