

**FEDERAL BUREAU OF INVESTIGATION
 U.S. DEPARTMENT OF JUSTICE
 DEATH CERTIFICATE - STANDARD FORM NO. 100-104**

59-034885

STATE FILE NUMBER

INDEXED

Registration District No. 333 Primary Registration District No. 3074 Registrar's No. 161

1. PLACE OF DEATH a. COUNTY Scott				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri COUNTY Mississippi					
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Sikeston		Length of stay in 1b 6 Weeks		c. CITY OR TOWN Charleston		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Bel Air Nursing Home			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) 200 N. Virginia St.		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Earle Middle Boyd Last Hearnes				4. DATE OF DEATH Month 9 Day 5 Year 59					
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 7/8/1881	9. AGE (last birthday) 78	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) Book Keeper			10b. KIND OF BUSINESS OR INDUSTRY Bertrand Gin Co.		11. BIRTHPLACE (City and state or country) Frederick, Ill.		12. CITIZEN OF WHAT COUNTRY USA		
13a. FATHER'S NAME William Beryle Hearnes			13b. MOTHER'S MAIDEN NAME Margaret Elizabeth Boyd			14. NAME OF HUSBAND OR WIFE Edna Hearnes			
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. 99-22-5186		17. INFORMANT Address Mrs. Edna Hearnes, Charleston, Mo.				
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>Cerebrovascular accident</u>							INTERVAL BETWEEN ONSET AND DEATH <u>12 hours</u>		
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Generalized arteriosclerosis.</u>									
DUE TO (c) _____									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Prior C.V.A.</u>					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 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>July 1959</u> to <u>9/5/59</u> and last saw ^{her} him alive on <u>9/4/59</u> Death occurred at <u>5:30 P</u> m on the date stated above, and to the best of my knowledge, from the causes stated.									
22a. SIGNATURE (Degree or title) <u>E.D. Urban M.D.</u>				22b. ADDRESS <u>Sikeston</u>				22c. DATE SIGNED <u>9/10/59</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>9/8/59</u>	23c. NAME OF CEMETERY OR CREMATORY <u>I.O.O.F. Cemetery</u>			23d. LOCATION (City, town, or county) (State) <u>Charleston, Mo.</u>			
24. FUNERAL DIRECTOR <u>The Nunlee Funeral Chapel</u> Address <u>Charleston, Mo.</u>				25. DATE RECD. BY LOCAL REG. <u>9-12-59</u>		26. REGISTRAR'S SIGNATURE <u>Mrs. Edna Hearnes</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 F. Munnick Jr.

Licensed Embalmer No. 3851

P. O. Address Charleston,

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.