

FEDERAL BUREAU OF INVESTIGATION

FURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-035208

FILED VS OCT 26 1959

STATE FILE NUMBER

Registration District No. 38 Primary Registration District No. 3006 Registrar's No. 593

| | | | |
|--|---|---|---|
| 1. PLACE OF DEATH | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) | |
| a. COUNTY <u>Boone</u> | b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Columbia</u> | a. STATE <u>Mo.</u> | b. COUNTY <u>Boone</u> |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>University of Mo. Medical Center</u> | | c. CITY OR TOWN <u>Columbia</u> | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |
| Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | | d. STREET ADDRESS (If outside, give location) <u>809 Rangeline Ave.</u> | Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |

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|---|-------------------------|--|---|--|-------------------------------------|
| 3. NAME OF DECEASED (Type or print) | | | 4. DATE OF DEATH | | |
| First <u>Alice</u> | Middle <u>McARTY</u> | Last <u>Sublett</u> | Month <u>10</u> | Day <u>20</u> | |
| 5. SEX <u>Female</u> | | 6. COLOR OR RACE <u>White</u> | 7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH <u>7-16-91</u> | 9. AGE (last birthday) <u>67</u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>-</u> | 11. BIRTHPLACE (City and state or country) <u>Boone Co., Mo.</u> | 12. CITIZEN OF WHAT COUNTRY <u>U.S.</u> | |
| 13a. FATHER'S NAME <u>JIM McARTY</u> | | 13b. MOTHER'S MAIDEN NAME <u>SARAH Miller</u> | | 14. NAME OF HUSBAND OR WIFE <u>Jabe Sublett</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u> | | 16. SOCIAL SECURITY NO. <u>-</u> | 17. INFORMANT <u>University of Mo. Medical Records</u> | | |

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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: | | INTERVAL BETWEEN ONSET AND DEATH |
| IMMEDIATE CAUSE (a) <u>Cardiac failure</u> | | <u>10-7 to</u> |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. | DUE TO (b) <u>Hypertensive Cardiovascular Renal disease</u> | <u>10-20-59</u> |
| DUE TO (c) | | |

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|--|--|--|--|
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>uremia</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 | |
|--|--|--|--|

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|--|---|--|--------------|
| 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 10-19-59 to 10-20-59 and last saw her ^{her} alive on 10-19-59
Death occurred at 2:20 A m on the date stated above, and to the best of my knowledge, from the causes stated.

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|---|--------------------------------|--|---|-------------------------------------|
| 22a. SIGNATURE (Degree or title) <u>Michael J. Anagnost M.D.</u> | | 22b. ADDRESS <u>U. of Mo. Med Center</u> | | 22c. DATE SIGNED <u>10-20-59</u> |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | 23b. DATE <u>10-22-1959</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>Olivet Cemetery</u> | 23d. LOCATION (City, town, or county) (State) <u>Boone Co., Missouri</u> | |
| 24. FUNERAL DIRECTOR <u>Parker Funeral Service, Columbia Mo</u> | | 25. DATE RECD. BY LOCAL REG. <u>Oct 21 1959</u> | 26. REGISTRAR'S SIGNATURE <u>Mrs. R.E. Palmer</u> | |

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

VS OCT 28 1959

JUN 1 1968

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 Donald L Roberts

Licensed Embalmer No. 4722

P. O. Address Columbia, Md

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.