

FEDERAL BUREAU OF INVESTIGATION
FEDERAL DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-035928

FILED VS NOV 9 1959

STATE FILE NUMBER

Registration District No. 128 Primary Registration District No. Registrar's No. 1168

ENDED

1. PLACE OF DEATH a. COUNTY <u>Greene</u>		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Greene</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Ash Grove</u>		c. CITY OR TOWN <u>Ash Grove</u>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION		d. STREET ADDRESS (If outside, give location)	
3. NAME OF DECEASED (Type or print) First Middle Last <u>GRACE</u> <u>ARBuckle</u>		4. DATE OF DEATH Month Day Year <u>Oct 29-1959</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. Married ☒ Never Married ☐ Widowed ☐ Divorced ☐	8. DATE OF BIRTH <u>March 8-1885</u>
9. AGE (last birthday) <u>74</u>		10. IF UNDER 1 YEAR Months Days Hours Min.	
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>At Home</u>	
11. BIRTHPLACE (City and state or country) <u>Centralia - Missouri</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A</u>	
13a. FATHER'S NAME <u>Andy Angel</u>		13b. MOTHER'S MAIDEN NAME <u>Lilly Dumbor</u>	
14. NAME OF HUSBAND OR WIFE <u>Charles Franklin Arbuckle</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>none</u>		17. INFORMANT Address <u>Charles F. Arbuckle - Ash Grove - Mo</u>	
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>Coronary Thrombosis</u> DUE TO (b) <u>Atherosclerosis</u> DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH	
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. ☐ Yes ☐ No ☐ Unknown	
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐	20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐	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 ☐ NOT WHILE AT WORK ☐		
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>Oct. 15 1959</u> to <u>Oct 29 1959</u> and last saw her alive on <u>Oct 29 1959</u> Death occurred at <u>10:50 p.m.</u> on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <u>C.F. Arbuckle</u> (Degree or title)		22b. ADDRESS <u>Ash Grove Mo</u>	
22c. DATE SIGNED <u>11/1/59</u>		23a. BURIAL, CREMATION, REMOVAL (Specify)	
23b. DATE <u>Nov 1-1959</u>		23c. NAME OF CEMETERY OR CREMATORY <u>St. Pleasant Cemetery</u>	
23d. LOCATION (City, town or county) (State) <u>Ash Grove (Greene) Mo</u>		24. FUNERAL DIRECTOR Address <u>Brown - Daniel - Ash Grove - Mo</u>	
25. DATE RECD. BY LOCAL REG. <u>11-3-59</u>		26. REGISTRAR'S SIGNATURE <u>Effie G. Meeten</u>	

(Licensed Embalmer's Statement on Reverse Side)

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 _____

Rory G. Ireland

Licensed Embalmer No. *5062*

P. O. Address *Walnut Grove*

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.