

# FEDERAL BUREAU OF INVESTIGATION U. S. DEPARTMENT OF JUSTICE

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# 59-036395

FILED VS NOV 2 1959

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Registration District No. \_\_\_\_\_ Primary Registration District No. 1002 Registrar's No. \_\_\_\_\_

5001

STATE FILE NUMBER

ENDED -

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Jackson</b>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Jackson</b>									
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Kansas City</b>		Length of stay in lb <b>10 years</b>		c. CITY OR TOWN <b>Kansas City</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>							
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Research Hospital</b>			Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <b>6505 East 12th St.</b>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>						
<b>3. NAME OF DECEASED</b> (Type or print) First <b>GEORGE</b> Middle <b>MUMFORD</b> Last <b>SCHOOLEY</b>				<b>4. DATE OF DEATH</b> Month <b>October</b> Day <b>15</b> Year <b>1959</b>									
<b>5. SEX</b> <b>Male</b>		<b>6. COLOR OR RACE</b> <b>White</b>		<b>7. Married</b> <input checked="" type="checkbox"/> <b>Never Married</b> <input type="checkbox"/> <b>Widowed</b> <input type="checkbox"/> <b>Divorced</b> <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <b>12/28/1870</b>		<b>9. AGE (last birthday)</b> <b>88</b>		IF UNDER 1 YEAR Months _____ Days _____ Hours _____ Min. _____		IF UNDER 24 HR Hours _____ Min. _____	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Salesman &amp; Collector</b>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>Auto. agency</b>		<b>11. BIRTHPLACE</b> (City and state or country) <b>Orrick, Missouri</b>		<b>12. CITIZEN OF WHAT COUNTRY</b> <b>U.S.A.</b>					
<b>13a. FATHER'S NAME</b> <b>William Schooley</b>				<b>13b. MOTHER'S MAIDEN NAME</b> <b>Mary Taylor</b>				<b>14. NAME OF HUSBAND OR WIFE</b> <b>Cecile N. Kephart Schooley</b>					
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>			<b>16. SOCIAL SECURITY NO.</b> <b>499-14-1204A</b>			<b>17. INFORMANT</b> <b>Mrs. Cecile Schooley, 6505 E. 12th, K.C. Mo.</b>			Address				
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Post operative death - Fracture of hip</b>										INTERVAL BETWEEN ONSET AND DEATH <b>4 days</b>			
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____										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			
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			
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		<b>20a. ACCIDENT</b> <input checked="" type="checkbox"/> <b>SUICIDE</b> <input type="checkbox"/> <b>HOMICIDE</b> <input type="checkbox"/>		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in PART I or PART II of item 18.) <b>Fell at home</b>									
<b>20c. TIME OF INJURY</b> Hour _____ a.m. _____ p.m.		Month, Day, Year <b>Oct 11, 1959</b>		<b>20d. INJURY OCCURRED WHILE AT WORK</b> <input type="checkbox"/> <b>NOT WHILE AT WORK</b> <input checked="" type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>Home</b>		<b>20f. CITY, TOWN, OR LOCATION</b> <b>Kansas City</b>		COUNTY <b>Jackson</b> STATE <b>Mo.</b>			
<b>21. I attended the deceased from</b> <b>11-10-54</b> <b>to</b> <b>10-15-59</b> <b>and last saw him alive on</b> <b>10-15-59</b> Death occurred at <b>7:00 p.</b> m on the date stated above, and to the best of my knowledge, from the causes stated.													
<b>22a. SIGNATURE</b> (Degree or title) <b>Wilson H. Miller, M.D.</b>					<b>22b. ADDRESS</b> <b>4620 Independence Ave</b> <b>Kansas City, Mo.</b>					<b>22c. DATE SIGNED</b> <b>10-17-59</b>			
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <b>Burial</b>		<b>23b. DATE</b> <b>Oct. 18, 1959</b>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>New Hope Cemetery</b>			<b>23d. LOCATION</b> (City, town, or county) (State) <b>Richmond, Mo.</b>						
<b>24. FUNERAL DIRECTOR</b> <b>Thurman Funeral Home, Richmond, Mo.</b>					ADDRESS		<b>25. DATE RECD. BY LOCAL REG.</b> <b>10-17-59</b>		<b>26. REGISTRAR'S SIGNATURE</b> <b>Neva Minshall</b>				

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

Wilson H. Miller

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**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

*Levat Thurman*

Licensed Embalmer No. 4563

P. O. Address Richmond, Mo.

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.