

FEDERAL BUREAU OF INVESTIGATION - STANDARD CERTIFICATE OF DEATH

59-036953

FILED VS NOV 9 1959

Registration District No. 227 Primary Registration District No. 4339 Registrar's No. 42

STATE FILE NUMBER

ENDED

1. PLACE OF DEATH a. COUNTY <u>MONROE</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MO.</u> b. COUNTY <u>MONROE</u>					
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>PARIS</u>		Length of stay in 1b <u>6 YRS</u>		c. CITY OR TOWN <u>PARIS</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>W. LOCUST ST.</u>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>W. LOCUST ST.</u>			Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>STEPHENS JAMES TODD</u>				4. DATE OF DEATH Month Day Year <u>NOV. 5 1959</u>					
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</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>2-12-1879</u>	9. AGE (last birthday) <u>80</u>		IF UNDER 1 YEAR Months <u>8</u> Days <u>23</u> Hours <u>—</u> Min. <u>—</u>	IF UNDER 24 HR Hours <u>—</u> Min. <u>—</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED FARMER</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>GENERAL FARMING</u>		11. BIRTHPLACE (City and state or country) <u>MO.</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>		
13a. FATHER'S NAME <u>JAMES R. TODD</u>			13b. MOTHER'S MAIDEN NAME <u>SUSAN MALLORY</u>			14. NAME OF HUSBAND OR WIFE <u>OLLIE TODD</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>NO</u>		17. INFORMANT <u>MRS OLLIE TODD</u> Address <u>PARIS, 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>Consumption</u> <u>Discharge</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____								INTERVAL BETWEEN ONSET AND DEATH <u>2 yrs</u>	
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 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>Aug 14 57</u> to <u>Nov 5 1959</u> and last saw him alive on <u>Jan 5 59</u> Death occurred at <u>6:15 AM</u> on the date stated above, and to the best of my knowledge, from the causes stated.									
22a. SIGNATURE (Degree or title) <u>Tom M. Bennett MD</u>				22b. ADDRESS <u>PARIS, MO.</u>				22c. DATE SIGNED <u>11/5/59</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE <u>11/7/1959</u>	23c. NAME OF CEMETERY OR CREMATORY <u>LONG BRANCH CEM.</u>		23d. LOCATION (City, town, or county) (State) <u>10 MI. S.E. OF PARIS, MO.</u>				
24. FUNERAL DIRECTOR <u>E.H. AGNEW</u> ADDRESS <u>PARIS, MO.</u>				25. DATE RECD. BY LOCAL REG. <u>11-5-59</u>		26. REGISTRAR'S SIGNATURE <u>F.B. Barnett M.D.</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 E. H. Agnew

Licensed Embalmer No. 4000

P. O. Address Pais, 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.