

**FEDERAL BUREAU OF INVESTIGATION  
U.S. DEPARTMENT OF JUSTICE  
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RECEIVED

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**59-037525**

ENDED

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_ Registrar's No. **2 9500** STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Louis</b>		Length of stay in 1b		c. CITY OR TOWN <b>St. Louis</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>Bethesda Hospital</b>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>4176 Russell</b>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Baby</b> Middle Last <b>Day</b>				4. DATE OF DEATH Month <b>October</b> Day <b>13</b> Year <b>1959</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <b>10/13/1959</b>	9. AGE (last birthday)	IF UNDER 1 YEAR Months Days	IF UNDER 24 HR Hours Mjn. <b>1 15</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>			10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <b>St. Louis, Mo.</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.</b>	
13a. FATHER'S NAME <b>Clinton Day</b>			13b. MOTHER'S MAIDEN NAME <b>Leatha Johnson</b>		14. NAME OF HUSBAND OR WIFE <b>None</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>			16. SOCIAL SECURITY NO. <b>None</b>	17. INFORMANT Address <b>Clinton Day, 4176 Russell</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>ANoxia,</b> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>Premature Sep. of placenta</b> DUE TO (c) <b>Premature labor</b>							INTERVAL BETWEEN ONSET AND DEATH <b>2hr.</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>761.5</b>					PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" 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.) <b>761.5</b>			
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 <b>10/13/59</b> and last saw her/him alive on <b>10/13/59</b> . Death occurred at <b>10/13/59</b> on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE <i>Leatha Johnson</i> (Degree or title)				22b. ADDRESS <b>1115 Meramec</b>		22c. DATE SIGNED <b>10/13/59</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	23b. DATE <b>10-16-59</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Boss Cemetery</b>		23d. LOCATION (City, town, or county) <b>Boss, Mo.</b>			
24. FUNERAL DIRECTOR ADDRESS <b>Albert H. Hoppe, Inc., 4700 Washington Blvd.</b>				25. DATE RECD. BY LOCAL REG. <b>OCT 16 1959</b>	26. REGISTRAR'S SIGNATURE <i>Carl Smith, M.D.</i>		

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

INVESTIGATION

at 0.75

at 0.75

HEALTH DEPT.

INVESTIGATION

STATE (of ...)

Y.S.C.

Y.S.C.

of ...

...

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...

...

HEALTH DEPT.

...

...

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by

or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Student \_\_\_\_\_

Signature of Student Embalmer

Signed \_\_\_\_\_

Licensed Embalmer No. \_\_\_\_\_

P. O. Address \_\_\_\_\_

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.

*Not Embalmed*  
*Lawrence*