

FEDERAL BUREAU OF INVESTIGATION - STANDARD CERTIFICATE OF DEATH

59-038024

FILED VS NOV 6 1959

STATE FILE NUMBER

Registration District No. _____ Primary Registration District No. _____ Registrar's No. **2-9962**

MAILED

1. PLACE OF DEATH a. COUNTY _____ b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN ST. LOUIS, MISSOURI Length of stay in 1b _____ c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION BARNES HOSPITAL Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE New York b. COUNTY _____ c. CITY OR TOWN New York Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> d. STREET ADDRESS (If outside, give location) 680 MADISON Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	
--	--	---	--

3. NAME OF DECEASED (Type or print) First MAX Middle DONALD Last ROSE			4. DATE OF DEATH Month OCTOBER Day 29 Year 1959			
5. SEX M	6. COLOR OR RACE W	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH MAY-9-1885	9. AGE (last birthday) 74	IF UNDER 1 YEAR Months _____ Days _____ Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired AMERICA Radiator Co.		10b. KIND OF BUSINESS OR INDUSTRY DECATOR Mich.		12. CITIZEN OF WHAT COUNTRY U.S.A.		
13a. FATHER'S NAME GILBERT ROSE		13b. MOTHER'S MAIDEN NAME MARY Kelly		14. NAME OF HUSBAND OR WIFE _____		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) No NONE		16. SOCIAL SECURITY NO. YES _____		17. INFORMANT Address CLAYTON MO. DR. D.K. ROSE 230 LINDEN		

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PERNICIOUS ANEMIA Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) 290.0		INTERVAL BETWEEN ONSET AND DEATH 1 YEAR
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) ARTERIOSCLEROTIC HEART DISEASE		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 checked="" 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 AUGUST 4, 1919 to OCT. 29, 1959 and last saw her/him alive on OCT. 29, 1959 Death occurred at 12:30 A.M. on the date stated above, and to the best of my knowledge, from the causes stated.			

22a. SIGNATURE (Degree or title) F. R. Bradley M. D.		22b. ADDRESS BARNES HOSPITAL		22c. DATE SIGNED 10/29/59
23a. BURIAL, CREMATION, REMOVAL (Specify) CREMATION	23b. DATE 10/30/59	23c. NAME OF CEMETERY OR CREMATORY OAK GROVE CREMATORY	23d. LOCATION (City, town, or county) ST. LOUIS Co. Mo.	
24. FUNERAL DIRECTOR ADDRESS C. R. Lupton & Sons 7253 DELMAR.		25. DATE RECD. BY LOCAL REG. OCT 29 1959	26. REGISTRAR'S SIGNATURE Loan Smith. M. D.	

(Licensed Embalmer's Statement on Reverse Side)

G.P.

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

Clarence A. Murray

Licensed Embalmer No. *441*

P. O. Address *St. Louis, 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.