

FEDERAL BUREAU OF INVESTIGATION
 DEPARTMENT OF JUSTICE
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59-038346

FILED VS. NOV 16 1959 317

Primary Registration District No. 544 Registrar's No. 2931

STATE FILE NUMBER

RECEIVED

1. PLACE OF DEATH a. COUNTY St. Louis				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY Jefferson									
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Kirkwood		Length of stay in 1b DDA		c. CITY OR TOWN House Springs		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>							
c. FULL NAME OF (if NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Joseph			Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		d. STREET ADDRESS (if outside, give location) R. R. # 2		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) First John Middle Thomas Last Stroud				4. DATE OF DEATH Month Nov. Day 4 Year 1959									
5. SEX Male		6. COLOR OR RACE White		7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH Nov. 22, 35		9. AGE (last birthday) 23		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HR	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Military				10b. KIND OF BUSINESS OR INDUSTRY U.S. Air Force		11. BIRTHPLACE (City and state or country) St. Louis, Mo		12. CITIZEN OF WHAT COUNTRY USA					
13a. FATHER'S NAME Jim Stroud				13b. MOTHER'S MAIDEN NAME Marie Mosley				14. NAME OF HUSBAND OR WIFE None					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes 7/13/54 - Present				16. SOCIAL SECURITY NO. 499-34-5754		17. INFORMANT Address Jim Stroud Route 2, House Springs, Mo.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Crushed chest, head injury, hemorrhage and shock DUE TO (b) _____ 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. <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 checked="" 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.) Lost control of car he was operating which left roadway, went down an embankment and overturned									
20c. TIME OF INJURY Hour 1:20 XXXX p.m. Month 11 Day 4 Year 59													
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.) highway		20f. CITY, TOWN, OR LOCATION COUNTY STATE Jefferson Missouri									
21. I attended the deceased from _____, to _____ and last saw her/him alive on _____. Death occurred at _____ on the date stated above, and to the best of my knowledge, from the causes stated.													
22a. SIGNATURE <i>Raymond Hand</i> (Degree or title) Coroner								22b. ADDRESS Clayton, Mo.		22c. DATE SIGNED 11/10/59			
23a. BURIAL, CREMATION, or REMOVAL (Specify) REMOVAL 11-7-59				23c. NAME OF CEMETERY OR CREMATORY ST. MARTINS				23d. LOCATION (City, town, or county) (State) DITTMER Mo.					
24. FUNERAL DIRECTOR ADDRESS Schildknecht Funeral Home O'Fallon, Ill.				25. DATE RECD. BY LOCAL REG. 11-5-59		26. REGISTRAR'S SIGNATURE <i>John C. Murphy MD</i>							

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

STATEMENT BY LICENSED EMBALMER

NOT

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 Phillip H. Schildkraut

Licensed Embalmer No. Ill. 8547

P. O. Address O'Fallon, Illinois

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.